September 1981

PERSPECTIVES
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ON
MEDICAID AND MEDICARE MANAGEMENT

The Health Care Financing Administration

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PERSPECTIVES ON MEDICAID AND MEDICARE MANAGEMENT

SEPTEMBER, 1981
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INTRODUCTION

The HCFA **Medicaid/Medicare Management Institute (M/MMI)** provides a forum for exchange of ideas and expertise among States through conferences and publications, and maintains a clearinghouse of Medicaid management publications. **M/MMI** staff also conduct Medicaid and Medicare program training for HCFA employees, and coordinate HCFA's interface with the Medicare intermediary and carrier groups, including conferences for Medicare contractors.

As this publication's title reflects, we include articles on both Medicaid and Medicare operations; our purpose in this is to assure that a broader range of ideas and experiences are shared across HCFA's two major programs, Medicaid and Medicare.

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We see this publication as a joint effort. If it is to be successful, we must have contributions from the States and Medicare contractors, as well as their views on how well we are meeting their needs.

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COST CONTAINMENT IN NEW JERSEY'S DRUG PROGRAM

by SANFORD LUGER, R.Ph.

Introduction

New Jersey, along with many other States, has been exploring measures to contain costs in its Medicaid program. Today's challenge is to effectively and efficiently manage this program while proficiently serving Medicaid recipients. We try to avoid the less imaginative reaction of cutting benefits; instead, we look within, to our program operations, for areas amenable to cost containment efforts. This article briefly describes reimbursement techniques currently being used by the Bureau of Pharmacy Services in the Division of Medical Assistance and Health Services of New Jersey's Department of Human Services (New Jersey's Medicaid program) to pay for pharmaceutical and drug services, to effectuate savings, and to maintain quality.

New Jersey is an industrialized mostly urban State with a population of about eight million. Its Medicaid program, which began in January 1970, is a generous one and covers over 600,000 recipients.

Background

New Jersey provides a comprehensive array of pharmaceutical and drug services under its Medicaid program. Covered pharmaceutical services in our program include: prescribed drugs, legend and non-legend drugs (legend drugs are those which, by Federal law, bear the legend: "Caution: Federal law prohibits dispensing without prescription."); contraceptive devices and supplies; diabetic testing material; hypodermic syringes and/or needles; and, legend devices.

As part of our overall Medicaid cost containment campaign, we decided to try four new reimbursement techniques in our Medicaid pharmaceutical program. These are: *regressive discounts; drug capitation in long term care facilities; dispensing fees for legend drugs,* with increments for additional services; and, a *tape-to-tape incentive program.* This article discusses these four approaches, all of which are operating at this time, and New Jersey's successful experiences with them.

Our Medicaid program has used an automated claims processing system since its inception in 1970. The core of the New Jersey system is the National Drug Code Price File, the provider file, and the eligibility file. The structure of these files allows a great deal of flexibility with the data so that a number of variables can be included in pricing claims according to predetermined parameters.

Early New Jersey Drug Reimbursement Programs

Initially, New Jersey's Medicaid reimbursement for drugs was based on invoice cost to the provider. This was discarded in 1975 because the funding to undertake the necessary auditing effort became inadequate. Subsequently, reimbursement for drugs was based either on the lesser of Average Wholesale Price (AWP) of a particular product based on the State's interpretation of the most frequently purchased size plus a dispensing fee, or on the provider's usual and customary charge to the general public. As New Jersey's Medicaid program grew, it became apparent that our reimbursement system had to be adjusted in order to cut costs and be fair to the provider.

Our initial response to the problem was to start paying direct prices for certain frequently purchased drug products based on purchases of large package size (e.g., 500s and 1000s). We felt that savings on the selected products would be substantial (15 to 20 percent), and would save between one and two percent of the State's total drug costs. This change in reimbursement was proposed to the New Jersey Pharmaceutical Association (NJPhA) in 1975. Their immediate reaction was negative. The Association was concerned that the scheme affected reimbursement to all providers without regard to an individual provider's ability to purchase large sizes of the target products. This reimbursement scheme penalized pharmacies (especially small ones) which did not purchase drug products in large package sizes. The Medicaid staff considered this argument valid, and went back to the drawing board.

Regressive Discounts

In a parallel effort, in 1974 we developed a scheme of regressive discounts under which the State shares various discounts earned by pharmacists when they purchase drugs. The State recognized that, while all providers could not purchase drugs at the same discounts, almost all earn some discounts on purchases (exclusive of two percent discounts for cash payments).

At the time, we believed that when most drug providers purchased from wholesalers they earned between four and eight percent discounts off AWPs, and that large package sizes and direct purchases garnered an additional four to fifteen percent discount. The State chose to allow drug providers to retain the large package size and direct purchase discounts as a trade off against the fact that Medicaid's dispensing fees were not likely to be increased for about two years. Regressive discounts were set at AWP of the standard package size for drug providers billing Medicaid between $1 and $24,999 per year; two percent off AWP for providers billing between $25,000 and $49,999 per year; and, four percent off AWP for providers billing over $50,000 per year. This was acceptable to the NJPhA because it removed the negative impact on small providers and had the same result as applying large package size prices to all claims.

In late 1975, HEW (now HHS) instituted Maximum Allowable Cost (MAC), a drug reimbursement program established by an HEW regulation which defines the upper reimbursement limits for about 25 specific drug products. New Jersey had to choose between applying the Estimated Acquisition Cost (EAC), a drug reimbursement program established under the same regulation as the MAC program which defines the upper reimbursement limits for all drugs, or devising a way to achieve the same results without the problems inherent in the EAC system. At times, the information received by the New Jersey Medicaid program under the EAC system was not timely, sometimes six to nine months late, and, early on, we believed the information was faulty. The first data available indicated that EAC prices were unrealistic and unobtainable by a significant number of New Jersey's pharmacies. The EAC program had the same inherent weakness as New Jersey large package size approach: it assumed that all providers had identical capability to purchase the same products at the same price.

These problems led us to redefine our regressive discount structure to accommodate the concept of EAC and yet recognize the buying patterns of all drug providers. The "prudent buyer concept" notwithstanding, New Jersey opted not to try to force all pharmacies into the same mold. We believed that, within certain limits, all pharmacy providers should have the option of participating in the program. This option assures that all New Jersey Medicaid clients can obtain services within their own locality, and that the New Jersey Medicaid program will have a consistently high pharmacy participation rate in its program.

Upon analyzing New Jersey's drug discount structure, HHS Region II staff concluded that a provider's level of billing to the Medicaid program is not a true indicator of a provider's purchasing power on which to base discounts. This led New Jersey to its current regressive discount system which uses the total number of prescriptions filled from all segments of society—private, Medicaid, and other third parties—as the parameter for establishing pharmacy discounts. The discounts are structured into six categories shown in **Table 1.**

Our regressive structure results in an overall average discount of four percent off the AWP cost of all drugs. This represents an annual savings of approximately $1 million to the New Jersey Medicaid program, as shown in **Table 2.**

We recognize that this set of indicators based on prescription volume is imperfect. A system incorporating a provider's total volume of all drug trade purchases more closely approximates capacity to earn discounts based on total buying volume rather than only drug purchases. We are considering this approach for the future. In our opinion, the regressive discount approach offers equity to providers and States alike, and offers an incentive to the provider to operate within the realities of the marketplace and to become a prudent buyer.

Drug Capitation in Long Term Care Facilities

Although regressive discounts apply across the entire New Jersey Medicaid drug reimbursement system, they represent only one aspect of our cost containment measures. We consider quality of patient care an important part of our cost containment measures while we strive for equity in our drug reimbursement program.

New Jersey analyzed the cost/benefit ratios of its cost containment measures, considered the impact of such measures on quality of care, and the ripple effects of such measures on auxiliary services. This analysis led us to the conclusion that the way we reimbursed pharmaceutical services in long term care facilities warranted re-examination.

We noted that fee-for-service (pharmacist is reimbursed by a fiscal agent for the cost of the prescription drugs plus a standard, fixed

TABLE 1: Pharmacy Discounts Based on Volume

CATEGORY I —	0 — 14,999 prescriptions per year;	AWP (no discount)
CATEGORY II —	15,000 — 19,999 prescriptions per year;	AWP less 2% discount
CATEGORY III —	20,000 — 29,999 prescriptions per year;	AWP less 3% discount
CATEGORY IV —	30,000 — 39,999 prescriptions per year;	AWP less 4% discount
CATEGORY V —	40,000 — 49,999 prescriptions per year;	AWP less 5% discount
CATEGORY VI —	50,000 prescriptions and over per year;	AWP less 6% discount

TABLE 2: Savings on Legend Drug Cost Regressive Discount System: Calendar Year 1979

1.	Total Legend Drug Expenditure (includes dispensing fee) (Items 2 + 3)	$34,852,911
2.	Total Cost of Drugs Only	$24,112,351
3.	Total Cost of Professional Fees	$10,740,560
4.	Total No. Legend Claims (includes 714,675 long term care claims which do not include a professional fee.)	5,470,360
5.	Total No. Legend Claims with Professional Fee	4,755,595
6.	Average Contractual Professional Fee	$2.41
7.	Average Actual Professional Fee (Items 3 ÷ 5)	$2.26*
8.	Average Regressive Discount	4%
9.	Estimated Drug Cost at AWP	$25,117,032
10.	Estimated Savings with Regression (Items 9 − 2)	$ 1,004,681

*Determined by $10,740,560 ÷ 4,755,595. This lower fee is effected by usual and customary charges which are less than the Maximum Allowable Cost of the AWP cost, less a discount, if any, plus a professional fee.

professional fee) in a fixed, stable population is a disincentive to proper utilization review. We were also aware that the fee-for-service concept has been recognized by many State and Federal administrators as being expensive and difficult to administer. We believe the fee-for-service structure encourages waste of time, resources, and money. It may also encourage overutilization of services and drugs by not rewarding effective utilization review by pharmacists. Some critics also feel that fee-for-service is demeaning because it casts the provider/pharmacist solely as a merchandiser.

Our concerns about the inadequacy of fee-for-service led us to seek alternatives to our Medicaid long term care drug reimbursement methods. One alternative we identified was capitation (a uniform per capita payment) reimbursement. Under New Jersey's drug capitation reimbursement system, Medicaid prepays a pharmacist a uniform per capita fee (based on the pharmacist's average utilization of prescription services for a specified period—usually one month) per eligible Medicaid recipient, whether or not prescription services are actually ordered by each eligible recipient during the specified period. In return, the pharmacist provides all of these recipients' prescribed drugs during a specified period.

To a large degree, the concept of capitation has been borrowed from health maintenance organizations (HMOs). The HMO reimbursement system applies capitation to total patient care management. We apply the capitation concept to a single health care service—pharmaceutical services. This fee is a fixed daily amount which does not vary until the new rate is established.

Our search led us to two basic capitation methods in drug reimbursement. The first, which we did not adopt, is a total system covering both the ingredient cost and the dispensing fee. This total system, currently being tested under the Iowa State Medicaid drug program,* results in an inverse relationship between a pharmacist's income and the ingredient cost. Under the Iowa experiment, the State pays participating pharmacies a fixed amount at the beginning of each month for each Medicaid patient who agrees to patronize the particular pharmacy that month. The fewer the prescriptions and the lower the product cost, the greater the pharmacist's profit margin. Under the Iowa experimental capitation system, there has been over a five percent reduction in government drug prescription costs compared to the fee-for-service system, with no apparent loss of income for participating druggists. Under capitation, there appears to be more incentive for utilization control through professional interaction between pharmacists and doctors.

This total drug capitation system does, however, have some shortcomings. First, a pharmacist must assume full financial risk for serving a confined population. In an ongoing capitation system, the State will not indemnify the pharmacist as it did in the Iowa experiment. This would remove any incentive to prudent buying and utilization review. Additionally, when ingredient costs are included, the system's built-in incentives tend to emphasize economy while sacrificing quality. These incentives encourage a pharmacist to dispense a less costly, less effective drug product that may be of lower quality. It could even result in no drug product being dispensed which may cause an illness to progress to a more serious or even life threatening state. Such actions, obviously, have the potential of impairing the quality of patient care. The use of a State approved interchange list (a State approved list of drugs which can be substituted for other chemically equivalent drugs—the New Jersey Drug Utilization Review Council Formulary) circumvents the former problem (less effective or lower quality drugs), while it is hoped professional integrity and close scrutiny limit the latter (quality of patient care—no drug product being dispensed).

The second drug capitation reimbursement system—one now being used in New Jersey nursing homes—is the payment of a fixed daily or monthly dispensing fee per patient, plus reimbursement for ingredient cost. This method reduces the pharmacist's financial risk, but still provides incentive for utilization review. Both systems require effective monitoring of drug therapy regimens

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*See June and November 1980 *Perspectives* for a detailed discussion of this project.

by competent pharmacist consultants for the approach to work to the advantage of the patient, the provider, and the State.

Under both capitation systems, each facility contracts with a pharmacist consultant who reviews patient drug regimens and reports problems. The activities of the consultant pharmacist are, in turn, reviewed by Medicaid staff pharmacists. The New Jersey drug utilization review program reviews consultants' activities to assure that appropriate action is taken to correct misutilization. Action is initially linked to education of the consultant and redirection of review efforts. Failure of a consultant to perform adequately results in the State recommending that the facility terminate its contract with the pharmacist consultant.

Drug utilization review is a type of peer review. It monitors drug usage data, seeks to ascertain patterns of use and misuse, and tries to persuade prescribers, pharmacists, and patients to seek effective and economical ways of using drugs. In practical terms, misutilization of drugs costs money. A drug capitation system provides the financial incentive to pharmacists to initiate or take a more active role in drug utilization review. Any good utilization review program considers: What medications were used? In what quantity? Was it adequate, or more or less than necessary? How often was it used? How does it relate to the other medication being taken? Does it duplicate another drug in the same therapeutic class? What about drug reactions? Was it appropriate for the diagnosis? Was it cost effective?

In the past, too little attention was given to the dangers of drug abuse by the elderly and institutionalized populations, the heaviest users of licit drugs. We define drug abuse as over or under-utilizing of a drug(s) by a patient, and/or the inappropriate prescribing of drugs by a physician.

The unearthing of a report on a three year (1974-1976) New Jersey study which used a drug capitation reimbursement system in a large intermediate care facility for the mentally retarded further strengthened New Jersey's preference for the second long term care facility drug capitation reimbursement system. Lack of adequate data on patient care costs prior to initiation of the study made the study inconclusive. However, another aspect of the data collected during the study was helpful. When adjusted for inflation, drug costs from the beginning of the study to its end were almost the same. In addition, capitation appeared to have obtained wide acceptance among the various health care professionals. Further, more time was spent on patient care; and, medication, billing, and payment errors were reduced, as were drug pilferage and waste. Viewing the study data from that perspective made us believe another attempt seemed warranted.

In 1977, we began a capitation system (still operating) for pharmaceutical services (product costs are reimbursed separately) in the Medicaid Long Term Care Pharmacy Program. Since implementation, there has been a demonstrable drop in the average number of prescriptions per long term care patient. The bottom line, of course, is whether or not cost savings are realized and quality of patient care remains constant. While the latter is difficult to measure objectively, we firmly believe that patient care has not diminished in quality, and, if anything, has actually improved. A subjective evaluation of comments solicited from medical directors, nursing staff, and facility administrators operating under this drug capitation system reveals a high degree of acceptance and a general acknowledgment of improved patient care.

We have also achieved a reduction in pharmaceutical costs. A comparison of 1978 and 1979 costs under the drug capitation system with what our costs *would have been* under a fee-for-service system (after controlling for drug cost and population size), indicates savings of over $500,000 in 1978 and $900,000 in 1979, with total savings of almost $1.5 million over the two year period. For a program with total costs of $5.4 million and $5.9 million during those years, these are highly respectable results. (See **Table 3** at end of article.)

The fee-for-service system had many faults which, particularly in long term care settings, led to unwarranted costs, high error rates, and waste. We believe the capitation system encourages prudence, eliminates unnecessary prescriptions, and offers both fiscal and utilization controls. In addition, our capitation approach has encouraged pharmacists to delve into medication records management, nursing orders, doctors' orders, and drug interaction. These factors, we believe, mean lower cost and better care under the capitation system.

Capitation for pharmaceutical services works in long term care settings. Success in such settings depends on the various environmental factors in which the drug capitation system is used (e.g., the population, the cooperation and communication between the various health professions, etc.).

New Jersey's capitation reimbursement system for pharmaceutical services has proved viable in long term care settings when the payments are designed to cover only pharmacists' professional fees. Reimbursement for products have to be made separately and have to cover acquisition costs for the system to function successfully. New Jersey will keep its capitation program confined to long term care facilities for the present. We are analyzing our four year capitation experience with an open mind for possible application in other parts of our program.

Dispensing Fees for Legend Drugs

New Jersey has developed and is using a five tier pharmaceutical professional fee structure to assure Medicaid recipients' access to mainstream medicine. This program allows the pharmacist to select those services felt to be economically feasible to provide, or consistent with the pharmacist's philosophy. While it is arguable whether our fees are adequate, collectively or incrementally, the New Jersey system has attracted a provider network of over 99 percent of all pharmacies in the State.

Under this program, participating pharmacists are entitled to a basic fee designed to compensate them for absolute minimum services (e.g., dispensing the prescription only). Additional increments are added to the base fee for any or all of the four additional services discussed below. Each increment is assigned a monetary amount based on the value of the service to the client and the program. The values for each incremental service are based on frequency of need, importance to patients' welfare, importance in the total health care of the patient, and impact on availability of appropriate services to the Medicaid client.

New Jersey's dispensing fee for legend drugs dispensed by pharmacy providers serving Medicaid patients, other than those in long term care of facilities, is $2.50. Additional increments are given to pharmacists who also provide:

1. *Twenty-four hour emergency services* (increment—five cents). The provider must have a twenty-four hours per day, three hundred and sixty-five days per year prescription service available, and it must be available to Medicaid recipients.
2. *Regular delivery service* (increment—eight cents). The provider must have a prescription delivery service available to all Medicaid recipients on a regular daily basis.
3. *Patient consultation* (increment—eight cents). In addition to routinely monitoring patient profiles for drug interactions, contraindications, allergies, etc., where appropriate, the provider must discuss the course of drug therapy with the Medicaid patient. This discussion must include emphasis on compliance with the prescriber's orders; proper drug utilization; cautions about possible side effects; foods to avoid; proper drug storage conditions; and, any other information that will prove beneficial to the patient while on drug therapy.
4. *Impact allowance* (increment—nine cents). The provider must have a combined Medicaid and Pharmaceutical Assistance to the Aged program (PAA) prescription volume of at least 50 percent of his/her total prescription volume. Effective April 1, 1981, we began including pharmacists' long term care prescription volume in our computation of their total prescription volume when making our determinations concerning pharmacists' entitlement to the impact allowance.

Twenty-four hour service has been assigned a relatively low value because, while desirable and necessary, it is not a frequent occurrence. Patient consultation is considerably more important because of its impact on drug utilization and its role in quality of care. The increment for delivery is given weight equal to that for consultation, largely because of the added cost factor to the provider, but also to encourage the service. The impact allowance increment is given the highest value to encourage providers to locate or remain in areas of greatest need (e.g., inner cities). This has been particularly successful in causing providers to remain in these areas.

To receive any or all of these increments, a provider must certify annually to the Division of Medical Assistance and Health Services of New Jersey's Department of Human Services, on form FD-70 (see **Figure 1** at end of article), that one or more of the above services are being provided and/or that the provider is entitled to the impact allowance. Each claimed increment is subject to audit. If the New Jersey Medicaid program determines that a pharmacist erroneously received an increment, it must be repaid with an appropriate penalty.

The maximum total charge to the New Jersey Medicaid program for a legend drug, including the charge for the cost of medication and the dispensing fee, may not exceed the lowest of three charges: "cost" plus the dispensing fee for legend drugs; a pharmacist's usual and customary and/or posted or advertised charges; or other third party prescription plan charges.

A pharmacist choosing to increase or decrease the number and extent of services he/she wishes to provide on an annual basis must change the information on the FD-70 form filed annually. The agreed upon services are monitored by New Jersey staff under their post payment auditing process. Upon audit, each pharmacy must satisfy the Medicaid program that they are performing as agreed. The impact increment is determined by an onsite audit comparing the provider's annual prescription billings for Medicaid and PAA services to the total prescription volume reported on the FD-70. If the State determines a provider has contracted for a service(s) not performed, recoupment of the increment(s) plus interest is undertaken. Recoupment is retroactive to the date the agreement was signed. In addition, the provider's fee is reduced by the amount of the questioned increment, effective with the date of audit. The pharmacist is given the opportunity to again contract for the disallowed service, provided the service is performed. A second offense can result in prosecution for fraud.

New Jersey's dispensing fees for its legend drugs' program has reached a point of diminishing returns. Monetary values have not kept pace with marketplace realities. While the program is conceptually sound, we may soon reach the point that this program's incentives are not adequate enough to maintain the provider network at its present levels.

Tape-To-Tape Incentive Program

In its course of seeking methods to control costs, New Jersey has found that cost sharing is a significant incentive to encourage efficient management by providers. One area of cost frequently overlooked, but ripe for control, is the administrative costs of claims processing. Cost containment or cost avoidance efforts are usually directed at controlling benefit costs. Most reimbursement systems are automatically viewed as efficient and cost effective if they are automated and relatively free of operational or software problems. Rarely is an attempt made to identify administrative costs which can be reduced through incentives.

In examining administrative costs for claims processing, New Jersey found that, despite automation, the costs of the paper claims process were becoming increasingly expensive. Between 1974 and 1978 we experimented with accepting claims data on magnetic tape. Several large pharmacies were persuaded to submit Medicaid claims on tape because of substantially reduced turnaround time for payment. Additionally, prescription transcription errors were reduced to minimal levels, also resulting in faster payment and fewer rejects. The number of pharmacies using the automated paper claims process remained constant because only the largest pharmacies could afford the cost of implementing an automated system or contracting with a computer service.

We decided to take another look at our tape-to-tape program after the State of Texas instituted a highly successful program. In June 1978, we conducted a study of processing costs for hard copy claims versus magnetic tape. The study revealed a significant difference in costs, as much as 12 cents per claim more for hard copy than for magnetic tape. Obviously, when a system processes 12 million claims per year, a savings of even one or two cents per claim is significant.

Based on this analysis, we decided to develop an incentive to stimulate more providers to utilize magnetic tape for billing the Medicaid program. The incentive was to be financed by savings generated. We decided to rebate the provider a portion of our savings to offset increased provider costs in submitting magnetic tape claims. This offset, combined with faster turnaround time, better cash flow, and fewer rejects, proved to be the stimulus needed to convince providers to use "paperless" billing. We established a scale of incentives. It is based on the ratio of the number of tape claims to the number of total Medicaid and PAA claims paid in a given month.

We decided that the magnetic tape program would not become effective until at least 20 percent of claims were submitted on tape. In December 1978, New Jersey's nonincentive based tape claims program represented less than 16 percent of total claims. Because of publicity surrounding the new incentive, that percentage rose to 23 percent (a 44 percent increase) by January 1979, the month New Jersey's tape-to-tape incentive payment program for pharmacists began. The seven percent rise in tape claims represented a net savings of 10 cents per claim (after payment of incentive), or about $5,000 for that month.

Incentive payments are made when the total volume of paid magnetic tape Medicaid and PAA claims submitted by all pharmacy providers is at least 20 percent of the total volume of all paid Medicaid and PAA claims.

The incentive reimbursement payments schedule is as follows:

Paid Magnetic Tape Medicaid and PAA Claims comprise _____ % of all paid Medicaid and PAA Claims	*Amount of Incentive Payment*
20 - 29%	2 cents/tape claim
30 - 39%	3 cents/tape claim
40 - 55%	4 cents/tape claim
over 55%	5 cents/tape claim

The incentive payment is based on the percentage of magnetic tape claims paid in the previous month. If the volume of the previous month's paid magnetic tape claims is less than 20 percent of the total paid Medicaid and PAA claims, no incentive payments are made in the current month. A pharmacy provider's incentive payments begin with the month after the month in which the volume of paid magnetic tape Medicaid and PAA claims reaches 20 percent of the total paid Medicaid and PAA claims volume. A qualified tape-to-tape pharmacy provider receives a single separate incentive payment check for all tape Medicaid and PAA claims paid during the preceding month.

We review and average claims volume figures quarterly. Claims volume totals for the previous quarter determine the incentive amount for the next quarter. The incentive payment for tape claims is an additional fee increment over and above the dispensing fee allowed by the New Jersey Medicaid program.

In order to submit magnetic tape claims for the Medicaid or PAA programs, a pharmacy provider must complete form FD-103 (see **Figure 2** at end of article) and receive approval by New Jersey's Division of Medical Assistance and Health Services. As of October 1980, the percentage of tape claims in New Jersey has increased to 38 percent of the total paid Medicaid and PAA claims, a 137.5 percent rise over December 1978. On the average, this has resulted in annual savings of over $450,000 in administrative costs to the State Medicaid program. Even as our offset rises with the percentage of claims on tape, savings to the New Jersey Medicaid program will remain in the area of $450,000 per year. As the percentage increases beyond 55 percent, savings will increase even more because there is no further offset beyond five cents per claim.

The tape-to-tape program has proved successful and cost effective. As pharmacists' inhouse computer systems or outside service costs decline, we anticipate that more New Jersey pharmacists will avail themselves of tape-to-tape billing.

Conclusion

In this article we have described the New Jersey Medicaid program's drug cost containment efforts in somewhat general terms. We believe our efforts have been successful, without the loss of needed services by our State's Medicaid recipients. The author welcomes questions from other States. He can be contacted at 324 State Street, P.O. Box 2486, Trenton, New Jersey 08625. He can be reached by phone at 609-292-3756 (FTS 477-3756).

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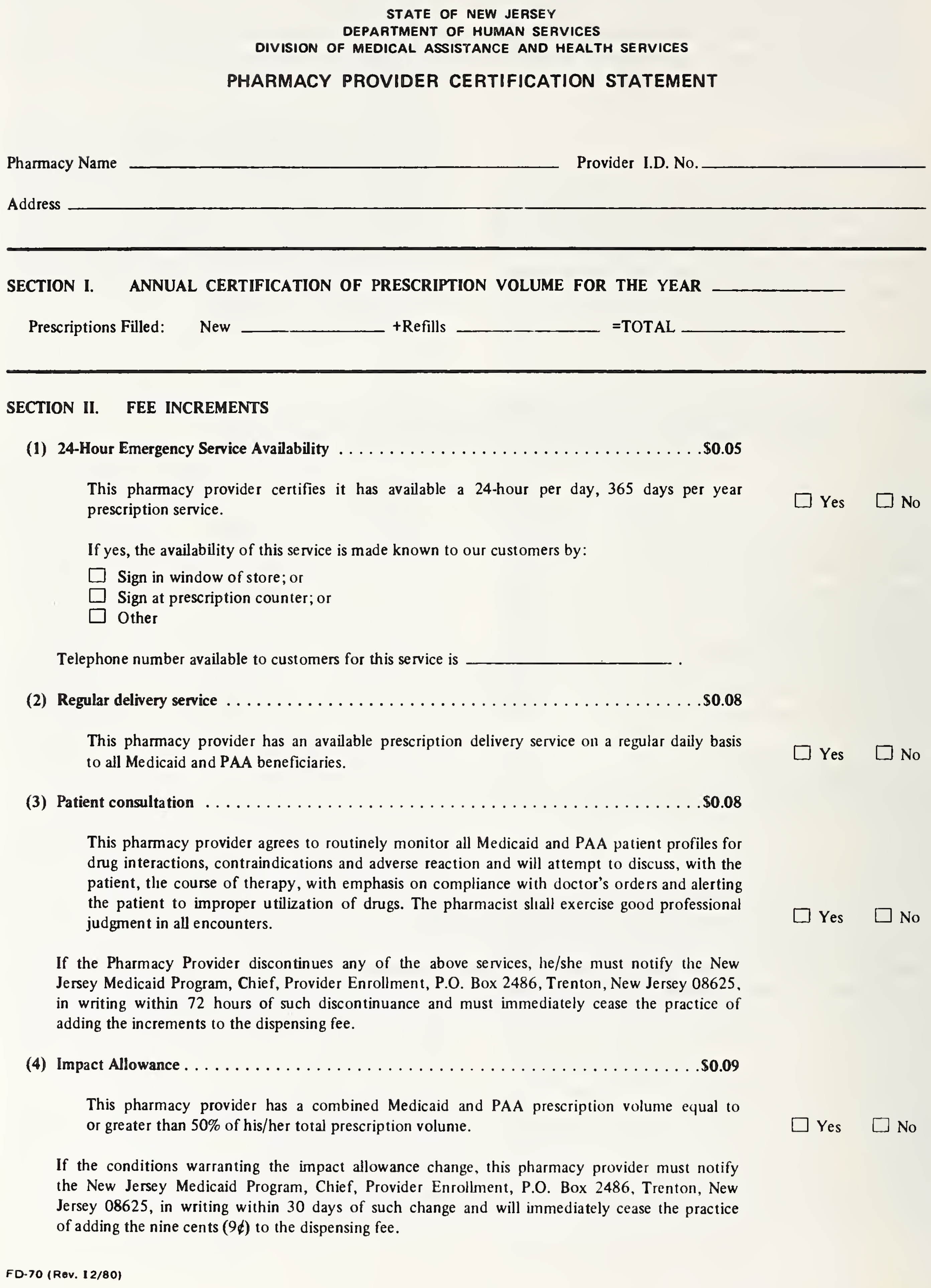
TABLE 3: Pharmacy Long Term Care Capitation System: Comparison of Fee-for-Service to Capitation Payment System

	Fee for Service Model[1]		*Calendar Year 1978*[2]	*Calendar Year 1979*[2]
	1976 A	*1976 B*		
1. Total No. of Long Term Care Claims	864,450	939,012	735,194	714,675
2. Average Drug Cost/Claim[3]	$4.47	$4.83	$4.47	$4.83
3. Average Daily Capitation/Fee/Claim	$2.41	$2.41	$0.34	$0.35
4. Average Daily Population	16,950	18,412	16,950	18,412
5. Average No. of Rx/Eligible/Month	4.25	4.25	3.6	3.2
6. Average Cost/Claim	$6.88	$7.24	$7.34	$8.23
7. Average Cost/Eligible/Month	$29.24	$30.77	$26.42	$26.62
8. Total Drug Cost	$3,864,092	$4,535,428	$3,292,191	$3,458,628
9. Total Capitation/Fee Payments	$2,083,325	$2,263,019	$2,103,512	$2,420,843
10. Total Cost (Items 8 + 9)	$5,947,417	$6,798,447	$5,395,703	$5,879,471
11. Savings Model A vs 1978	$5,947,417 – $5,395,703 = $551,714			
12. Savings Model B vs 1979	$6,798,447 – $5,879,471 = $918,976			
13. Total 2 Year Savings (Items 11 + 12)	$1,470,690			

NOTES:

1. 1976 is the base year prior to implementation of the Long Term Care Pharmacy Capitation System in July 1977. The model uses 1978 and 1979 dollars and populations as constants for comparison purposes. 1976 A and 1976 B relate to the comparison of 1978 dollars and 1979 dollars respectively.
2. 1978 and 1979 figures are from actual utilization data.
3. Actual average drug cost per claim rose 8 percent, which is consistent with inflation assuming quantities dispensed remained the same, while the average cost per eligible only rose by 0.8 percent. This is attributed to two factors: a) 15 percent decrease in the number of claims per eligible per month, and b) the increase in the population.

FIGURE 1:



STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PHARMACY PROVIDER CERTIFICATION STATEMENT

Pharmacy Name ______________________________ Provider I.D. No. ______________

Address ____

SECTION I. ANNUAL CERTIFICATION OF PRESCRIPTION VOLUME FOR THE YEAR __________

Prescriptions Filled: New __________ +Refills __________ =TOTAL __________

SECTION II. FEE INCREMENTS

(1) 24-Hour Emergency Service Availability $0.05

This pharmacy provider certifies it has available a 24-hour per day, 365 days per year prescription service. ☐ Yes ☐ No

If yes, the availability of this service is made known to our customers by:

☐ Sign in window of store; or
☐ Sign at prescription counter; or
☐ Other

Telephone number available to customers for this service is ____________________.

(2) Regular delivery service $0.08

This pharmacy provider has an available prescription delivery service on a regular daily basis to all Medicaid and PAA beneficiaries. ☐ Yes ☐ No

(3) Patient consultation $0.08

This pharmacy provider agrees to routinely monitor all Medicaid and PAA patient profiles for drug interactions, contraindications and adverse reaction and will attempt to discuss, with the patient, the course of therapy, with emphasis on compliance with doctor's orders and alerting the patient to improper utilization of drugs. The pharmacist shall exercise good professional judgment in all encounters. ☐ Yes ☐ No

If the Pharmacy Provider discontinues any of the above services, he/she must notify the New Jersey Medicaid Program, Chief, Provider Enrollment, P.O. Box 2486, Trenton, New Jersey 08625, in writing within 72 hours of such discontinuance and must immediately cease the practice of adding the increments to the dispensing fee.

(4) Impact Allowance $0.09

This pharmacy provider has a combined Medicaid and PAA prescription volume equal to or greater than 50% of his/her total prescription volume. ☐ Yes ☐ No

If the conditions warranting the impact allowance change, this pharmacy provider must notify the New Jersey Medicaid Program, Chief, Provider Enrollment, P.O. Box 2486, Trenton, New Jersey 08625, in writing within 30 days of such change and will immediately cease the practice of adding the nine cents (9¢) to the dispensing fee.

FD-70 (Rev. 12/80)

I HAVE THOROUGHLY READ THE PHARMACY PROVIDER CERTIFICATION STATEMENT AND AGREE TO THE TERMS AND CONDITIONS SET FORTH HEREIN. I UNDERSTAND THAT THE MAXIMUM CHARGE TO THE NEW JERSEY MEDICAID PROGRAM FOR A MEDICAID OR PAA PRESCRIPTION FOR A LEGEND DRUG, INCLUDING THE CHARGE OF THE COST OF MEDICATION AND THE DISPENSING FEE, MAY NOT EXCEED THE LOWEST OF THE FOLLOWING:

(A) cost plus dispensing fee as outlined in the New Jersey Medicaid Program Pharmacy Manual; or
(B) usual and customary and/or posted or advertised charge; or
(C) other third party prescription plan charges or contractural agreements.

L.S. ______________________________ Date: ______________

Name and Title ______________________________
(Please print – owner, president, other-specify)

NOTE: (1) All of the above statements are subject to audit and review by Division personnel, its contractors, or other state and federal agencies duly authorized.

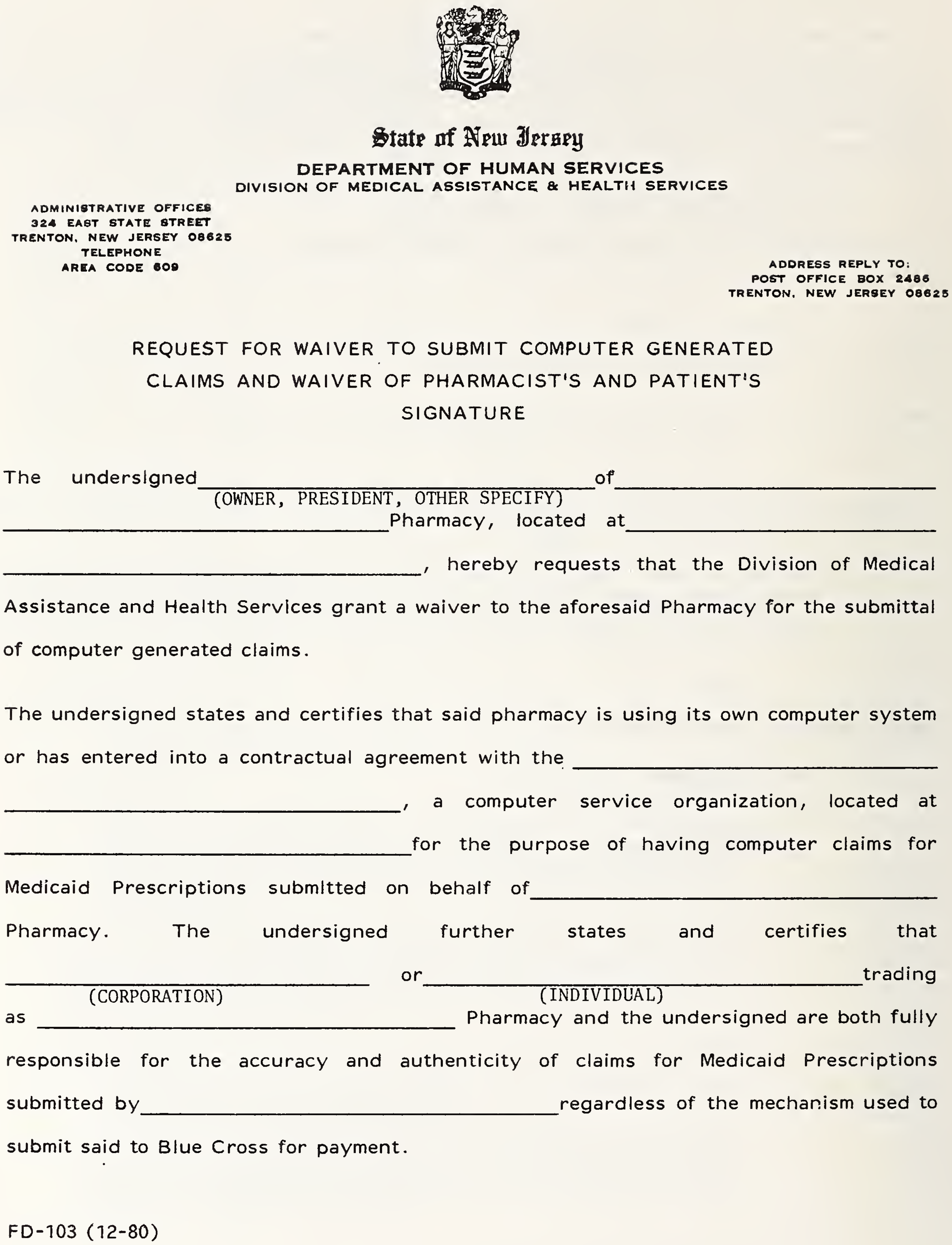
(2) Each claimed increment (Section II) is subject to audit. If the New Jersey Medicaid Program determines, upon audit, that the pharmacy provider has an error rate of 5% or more for a claimed increment, the New Jersey Medicaid Program will recover the total reimbursement paid to the pharmacy for that increment, plus interest charges, retroactive to the date of this agreement.

PLEASE RETURN THIS FORM WHEN COMPLETED TO:

Pharmacy Relations Department
Blue Cross of New Jersey
33 Washington Street
Newark, New Jersey 07102

FD-70 (Rev. 12/80)

FIGURE 2:



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE & HEALTH SERVICES

ADMINISTRATIVE OFFICES
324 EAST STATE STREET
TRENTON, NEW JERSEY 08625
TELEPHONE
AREA CODE 609

ADDRESS REPLY TO:
POST OFFICE BOX 2486
TRENTON, NEW JERSEY 08625

REQUEST FOR WAIVER TO SUBMIT COMPUTER GENERATED CLAIMS AND WAIVER OF PHARMACIST'S AND PATIENT'S SIGNATURE

The undersigned ______________________ of ______________________
(OWNER, PRESIDENT, OTHER SPECIFY)
______________________ Pharmacy, located at ______________________

______________________, hereby requests that the Division of Medical Assistance and Health Services grant a waiver to the aforesaid Pharmacy for the submittal of computer generated claims.

The undersigned states and certifies that said pharmacy is using its own computer system or has entered into a contractual agreement with the ______________________

______________________, a computer service organization, located at ______________________ for the purpose of having computer claims for Medicaid Prescriptions submitted on behalf of ______________________ Pharmacy. The undersigned further states and certifies that ______________________ or ______________________ trading
(CORPORATION) (INDIVIDUAL)
as ______________________ Pharmacy and the undersigned are both fully responsible for the accuracy and authenticity of claims for Medicaid Prescriptions submitted by ______________________ regardless of the mechanism used to submit said to Blue Cross for payment.

FD-103 (12-80)

The undersigned provider certifies that all information contained in its computer generated claims is true, accurate and complete; and agrees to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State Agency may request; and that the services covered by all such claims and the amounts charged therefore are in accordance with the regulations of the New Jersey Medicaid and PAA Programs, and that no part of the net amounts payable under such claims has been paid; and that payment of such amounts will be accepted as payment in full without additional charge to the patients or to others on their behalf. The undersigned also certifies that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act. It is understood that payment and satisfaction of all claims will be from Federal and/or State funds and that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State laws, or both.

The undersigned further certifies as follows: that no information, data, or summaries of same will be given to any agency or organization without written consent from the Division of Medical Assistance and Health Services. If a computer service organization is utilized by the undersigned, the contract between said computer service organization and the Pharmacy shall contain a clause guaranteeing the confidentiality of all records and data. All medicaid payments for the above mentioned computer generated claims are to be made directly to the aforesaid Pharmacy. The undersigned further certifies that no "factoring" i.e., percentage of claim payments diverted to the computer service organization is involved in the agreement with______________________________________.

(Computer Service Organization)

FIGURE 2: Continued

THE________________________________PHARMACY FURTHER REQUESTS WAIVER OF THE FOLLOWING:

PHARMACIST'S SIGNATURE YES__________ NO__________

PATIENT'S SIGNATURE YES__________ NO__________

The Undersigned certifies that for each Medicaid Prescription claim submitted for payment the patient's signature is on file at____

(NAME AND ADDRESS

____

(OF PHARMACY)

The undersigned further certifies that he has read, fully understands and will comply with the above.

SIGNATURE ____

(OWNER, PRESIDENT, OTHER (SPECIFY)

____

Corporate
Seal

(NAME, PLEASE PRINT)

____

(STREET ADDRESS)

____

CITY STATE ZIP CODE

SIGNATURE ____

PHARMACIST IN CHARGE

IOWA MEDICAID/TITLE IV-D DEMONSTRATION PROJECT

by AL STORMS and STAN MONROE

Introduction

In the past decade, Medicaid expenditures have grown at twice the rate of the number of recipients in the program. Dramatic inflation in health care costs is one main reason Medicaid costs have grown so rapidly. Another significant factor explaining the increase in program expenditures is the failure of State Medicaid agencies to determine liable third party medical coverage for Medicaid recipients. A third party is any individual, entity or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient. Tapping third party resources can reduce some of the escalating costs in the Medicaid program.

We will discuss one source of commercial health insurance which has not been pursued thoroughly by Iowa, and, we suspect, by many other State Medicaid agencies, i.e., policies carried by absent parents that cover dependent children. Identifying these policies is difficult for States since the caretaker relative who most often is the person who applies for assistance is frequently unable or unwilling to provide information on health insurance carried by an estranged spouse. In addition, child support agencies are reluctant to divert staff resources from their primary mandate of child support enforcement. Consequently, absent parent third party resources have remained largely untapped.

Section 11 of Public Law 95-142, effective in January 1978, authorizes State Medicaid agencies to arrange with and pay State Title IV-D agencies (child support enforcement agencies) to identify liable third party resources available through absent parents. Medicaid agencies, however, are reluctant to pay the Title IV-D agency for services without knowing the cost effectiveness of these activities.

Shortly after implementing regulations became effective in May 1980, information from studies in Idaho and Massachusetts began circulating among other States indicating that absent parent medical insurance may be of great significance in controlling or reducing Medicaid costs. According to the Idaho study, 143 instances of absent parents with dependent health insurance coverage were found by calling only 55 employers. A mass mailing to absent parents in Massachusetts found 2,600 absent parents with dependent health coverage.

In determining if absent parent resources would be as productive in the States in Region VII, a demonstration project to identify third party resources available through absent parents was presented by the Kansas City Regional Office of HCFA to Iowa Medical Services; a joint project between the regional office and Iowa then began. We decided to test this absent parent resources program on a small scale before considering it Statewide. At this point, we contacted the Kansas City Regional Office of Child Support Enforcement (OCSE) and the Iowa State Title IV-D agency to receive their approval and support for this project. Both the Federal and State offices of child support enforcement endorsed the demonstration project, and the OCSE regional office offered assistance in reviewing case files at the county Title IV-D office selected.

After discussions with the Iowa child support office, we chose the Marshall County Title IV-D office for the project since their case records were better documented and organized than other counties, and since Marshall County has two relatively large employers.

The Project: Key Features

In October 1980, cases at the Marshall County Title IV-D office were reviewed by staff from both the regional offices of HCFA and Child Support Enforcement, and Iowa Medical Services. There was a total of 526 cases in Marshall County; 330 of those had court orders for divorce, separation or paternity. We limited our review to the 330 cases with court orders since Title IV-D case files contain only limited information before a court order is established. Following are the procedures we used during the project.

We began by reviewing 288 of the 330 Title IV-D cases with court orders (42 cases were unavailable for our review), and recording the absent parent's name, address, Title IV-D case number, Social Security number, birth date, and employer's name and address on the project worksheet. (See **Figure 1** at end of article). We also recorded the caretaker relative's name, names of the dependent children who were Medicaid recipients, court ordered medical support information, and health insurance information. We identified 85 (30 percent) cases with medical support specified in the court order and 203 (70 percent) without.

We decided to pursue only those cases in which a child support payment had been made by the absent parent within the past seven months. Due to staff and budget restrictions, we reasoned that if the Title IV-D agency had not been able to get the absent parent to pay child support (food, shelter and clothing, etc.), it would be just as unproductive to attempt identification of health insurance. We eliminated 80 of the 288 cases from further review either because the absent parent had not made a child support payment within the past seven months, or because the absent parent had made a support payment but the file contained neither an address nor employment information. With the remaining 208 cases, we checked the dependents' names against the Medicaid eligibility file, and recorded their Medicaid identification number and any third party resources identified.

Of the 208 cases with a child support payment within the 7 month period, 151 contained employment information from 103 separate employers. We then called the 103 employers and asked them these questions:

— Is health insurance available through employment?

— If yes, are dependents covered under the policy?

— If yes, what types of services are covered and what are the deductible and copayment arrangements?

— What is the name and address of the insurance company, the policy number, and effective coverage date?

Of the 151 cases with employment information, we found 36 cases with health insurance which had not previously been identified at AFDC intake, and 27 cases with policies reported at intake, but without all covered services listed. A total of 63 cases (42 percent) was identified as having new or additional insurance. We eliminated 31 of the 88 remaining cases with employment information from further followup, either because their insurance had been identified and coded correctly at AFDC intake, or because the absent parent was no longer employed and an address was unknown. Of the 88 cases with employment information, one or more of the following situations existed: we couldn't reach the employer by telephone; we did not receive insurance information from the employer; there was no insurance through employment; insurance was identified and coded correctly at AFDC intake; and/or, the absent parent no longer worked at that place of employment.

Insurance questionnaires (see **Figure 2** at end of article) were mailed on 114 of the 208 cases. Thirty-five questionnaires were returned for a 32 percent response rate. Seven of the responding absent parents listed dependent health insurance coverage that corresponded to the October 1979 through December 1980 review period.

In sum, from the 208 cases we worked with, 151 contained employment information. We identified new or additional insurance in 63 of the 151 cases, and one or more of the above mentioned situations occurred on the remaining 88 cases. Insurance questionnaires were sent on 114 cases: 57 without employment information and 57 remaining from the group on which we had called the employers listed from the Title IV-D file. We sent questionnaires to the second group because our employment information may not have been current, or they might have had private health insurance policies which covered their dependents.

We identified a total of 70 cases with new or additional health insurance from the 208 cases. The 70 cases represent 63 identified by calling the employer and 7 by responding to the questionnaire. Thirty-four (49 percent) of the 70 cases had medical support in the court orders and 36 (51 percent) did not.

In our last step, we requested that the Iowa State Medicaid agency provide paid Medicaid claims histories for the 70 dependent children covered by policies during the review period October 1979 through December 1980. We added the amounts Iowa Medicaid paid for services also covered by third party policies during the 15 month review period or from the effective date of coverage, if shorter. If there was a per person deductible or a percent of copayment, these amounts were deducted. On policies previously reported, we included only amounts paid for additional services discovered by calling the employers.

We found that $17,322.97 had been paid by Medicaid which could have been avoided if these policies or all services covered by the policies had been identified. This is an average of $60.15 per case on the original 288 cases reviewed. Medicaid paid in error $13,388.31 or $352.32 per new policy identified and $267.76 per covered recipient on 38 policies not previously identified.

Estimated Savings from Statewide Application

Table 1 is our projection of the gross savings, expenses and net savings from a Statewide Medicaid/Title IV-D program to identify absent parent health insurance resources.

The 12 month Statewide projected savings on absent parent health insurance resources, based on our experience in Marshall County, is $1,467,298.01. Since each county has a different rate of employment and percent of cases with court ordered medical support, etc., the actual savings might be less or possibly more. Even though there may be some variance in the net savings, we believe the project demonstrates that a Statewide program to identify absent parent medical resources would result in substantial savings of State and Federal expenditures.

If this project is extended to Statewide implementation in Iowa, we recommend the following:

- To establish a current data base, the Iowa Medicaid agency should complete a one time mass mailing of an insurance questionnaire to absent parents with court orders for child support. It might also be worthwhile to mail questionnaires to absent parents without court orders even though we did not include these absent parents in this project. We suggest the agency first complete a test mailing in a limited area to determine if this is productive.
- In Iowa, the Title IV-D caseworker deals directly with the absent parent while the Title IV-A social worker works with the AFDC caretaker relative. We suggest that during the Title IV-D caseworker's first interview, he or she should question absent parents with court ordered child support about employment and insurance. Regardless of what insurance information the absent parent gives, it should be standard procedure for caseworkers to call the employer to confirm the service coverage and to obtain the insurance billing instructions. The Title IV-D caseworker or the Title IV-A social worker may call the employer; however, the Title IV-A social worker is responsible for including the information in the AFDC case file and the dependent's Medicaid eligibility file. When a change of employment is noted for an absent parent, the insurance information should be checked by either of these methods, and the appropriate files updated.
- The Title IV-D agency should include medical support if available through employment in all court orders that they process. Statistics from this project indicate that court orders requiring support result in more cases in which ab-

sent parents carry medical insurance. As indicated previously, only 30 percent of all cases reviewed contained court orders for medical support, while 49 percent of those with health insurance had medical support specified in the court orders.

If Iowa implements this program Statewide, we feel strongly that to document the program's effectiveness statistics should be accumulated on the number of health insurance policies identified and the amount of Medicaid payments avoided. The number of cases identified may be more important than a dollar avoidance figure since many providers will note the medical insurance code on the recipient's identification card, bill the third party, receive payment, and Medicaid is never aware of the transaction. For this reason, it is not possible to document all of the money saved in a third party liability (TPL) cost avoidance system.

Finally, in order to accumulate, process, and use insurance information in a satisfactory manner, it is essential that a State allocate sufficient resources for each step of the process. Results should be well worth the expenditures.

TABLE 1: 12 Month Statewide Projection

GROSS SAVINGS		
A.	Calling employers on new court ordered Title IV-D cases—(Multiply the number of new court ordered cases with dependent coverage per year* by the amount of each new insurance policy identified.)	$1,398,307.46
B.	Mass mailing to court ordered cases in order to establish a data base—(Multiply the number of estimated cases having new or additional insurance by the amount that can be avoided per case interviewed.)	99,307.65
	TOTAL	$1,497,615.11
LESS EXPENSES		
A.	Cost to the Title IV-D or Title IV-A agency for calling employers on new court ordered cases—(Add the costs of calling employers, recording information and entering the information into the Medicaid eligibility file.)	$ 22,327.20
B.	Cost of mass mailing and recording information—(Add the costs of mailing the questionnaires to absent parents, return postage, and the estimated costs of transferring data to Title IV-A, and Title IV-A entering the information into the Medicaid eligibility file.)	7,989.90
	TOTAL	$ 30,317.10
NET SAVINGS		
	Gross Savings—	$1,497,615.11
	Less Expenses—	−30,317.10
	TOTAL	$1,467,298.01

*We divided the total savings by the number of cases per new case identified. We then subtracted one-fifth to make the amount for 12 months since the original figure was for a 15 month period.

Conclusion

Federal regulations require States to take reasonable measures to identify third party liability medical care coverage; treat third party resources as payment for health care services; and, effect procedures for securing reimbursement from liable third parties.

The Iowa-Marshall County demonstration project shows an effective means of identifying, tracking, and monitoring Medicaid claims with third party resources, specifically policies carried by absent parents that cover dependent children.

- *Al Storms is a Medicaid/Medicare Operations Specialist in the Division of Program Operations in HCFA's Kansas City regional office. Before that, he worked for HCFA's Division of Quality Control investigating fraud, abuse and waste. Prior to joining HCFA, he worked for the National Center for Disease Control with assignments in various States.*

- *Stan Monroe is a Medical Field Analyst in the Utilization Review Section of the Bureau of Medical Services. He established and has headed the Third Party Liability Unit in Iowa's Department of Social Services since 1977.*

FIGURE 1: Title IV-D TPR Demonstration Project

Worksheet

1. Absent parent name: ______________________________ IV-D Case No.: __________
2. Address: ______________________________ Phone Number: __________
3. Dependents names:
   1. ______________________________
   2. ______________________________
   3. ______________________________
   4. ______________________________
   5. ______________________________
4. Does file contain information on: ________ recent payment ________ reliable employment
5. Employers name: ______________________________
   Employers address: ______________________________
6. Court ordered medical payments: ________ yes ________ no
7. Insurance information in file ________ yes ________ no
   a. If yes, code: Insurance Company ______________ Services Covered __________
   b. Policy Number: ______________________________

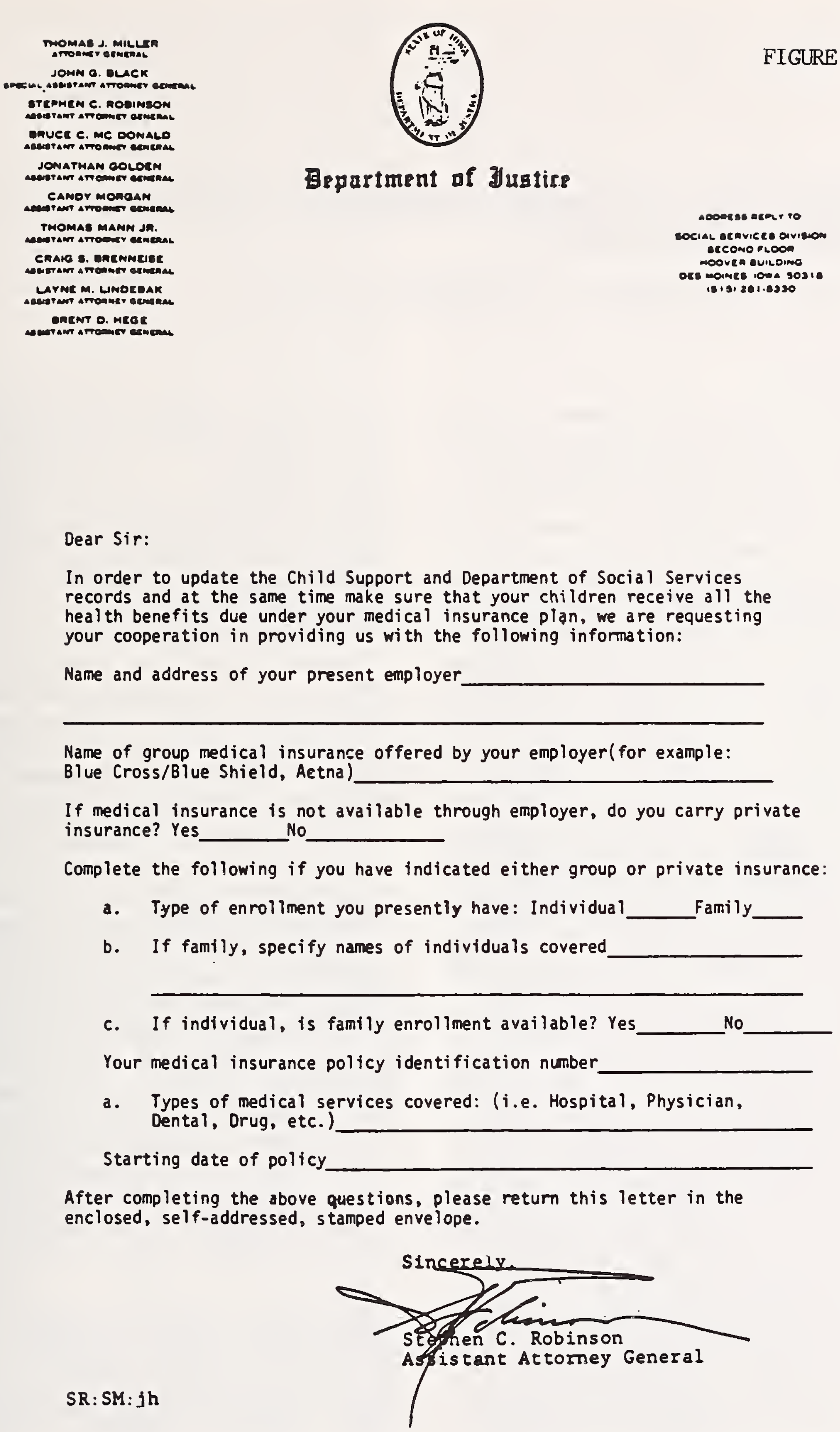
Insurance Information

1. Information obtained by: ______________ mailing ________ contacting employer
2. Is health insurance available through employment? ________ yes ________ no
   a. Are dependents covered? ________ yes ________ no
   b. Does policy require assignment? ________ yes ________ no
   c. Types of services coverage code: ______________
   d. Insurance Company code: ______________
   e. Policy Number: ______________
   f. Effective coverage or employment date: ______________

- -

3. Private insurance:
   a. Are dependents covered? ________ yes ________ no
   b. Does policy require assignment? ________ yes ________ no
   c. List dependents names:
      1. ______________________________
      2. ______________________________
      3. ______________________________
      4. ______________________________
      5. ______________________________
   d. Types of services coverage code: ______________
   e. Insurance Company code: ______________
   f. Policy Number: ______________
   g. Effective coverage date: ______________

FIGURE 2



THOMAS J. MILLER
ATTORNEY GENERAL
JOHN G. BLACK
SPECIAL ASSISTANT ATTORNEY GENERAL
STEPHEN C. ROBINSON
ASSISTANT ATTORNEY GENERAL
BRUCE C. MC DONALD
ASSISTANT ATTORNEY GENERAL
JONATHAN GOLDEN
ASSISTANT ATTORNEY GENERAL
CANDY MORGAN
ASSISTANT ATTORNEY GENERAL
THOMAS MANN JR.
ASSISTANT ATTORNEY GENERAL
CRAIG S. BRENNEISE
ASSISTANT ATTORNEY GENERAL
LAYNE M. LINDEBAK
ASSISTANT ATTORNEY GENERAL
BRENT D. HEGE
ASSISTANT ATTORNEY GENERAL

Department of Justice

ADDRESS REPLY TO

SOCIAL SERVICES DIVISION
SECOND FLOOR
HOOVER BUILDING
DES MOINES IOWA 50319
(515) 281-8330

Dear Sir:

In order to update the Child Support and Department of Social Services records and at the same time make sure that your children receive all the health benefits due under your medical insurance plan, we are requesting your cooperation in providing us with the following information:

Name and address of your present employer________________________________

____

Name of group medical insurance offered by your employer(for example: Blue Cross/Blue Shield, Aetna)______________________________

If medical insurance is not available through employer, do you carry private insurance? Yes________No__________

Complete the following if you have indicated either group or private insurance:

a. Type of enrollment you presently have: Individual______Family_____

b. If family, specify names of individuals covered________________

____

c. If individual, is family enrollment available? Yes________No________

Your medical insurance policy identification number_______________

a. Types of medical services covered: (i.e. Hospital, Physician, Dental, Drug, etc.)______________________________

Starting date of policy______________________________

After completing the above questions, please return this letter in the enclosed, self-addressed, stamped envelope.

Sincerely,

Stephen C. Robinson
Assistant Attorney General

SR:SM:jh

FLORIDA BLUE CROSS/BLUE SHIELD'S ELECTRONIC CLAIMS SUBMISSION PROCESS

by JACQUELYN ADKINS and GWENDOLYN CLINE

Introduction

In October 1974 Blue Cross and Blue Shield of Florida, Inc. (referred to as the "Plan") received the first electronic submission of claims data from remote physician and hospital billing offices in the State via WATS (Wide Area Telecommunications Service). This marked the successful completion of an automated polling (scheduled data transmission) network, a project begun in August 1973. The project was initiated by the Jacksonville based Plan out of a recognized need to reduce the growing volume of claims paperwork. The automated claims polling system promised to meet such a need, and to provide a mechanism for maintaining accurate records and assuring rapid claims settlement. The term "paperless processing" was quickly established and became synonymous with this mode of claims submission.

The system, known as Electronic Medium Claims (EMC), initially consisted of only Texas Instruments (T.I.) 742 terminals. However, as the network grew, other electronic media, such as mini computers (computer-to-computer), were tested and added. Other billing agencies, using computer generated paper billing, began altering their system to record claims information on magnetic tape for mailing to the Plan. The three modes of EMC submission accommodate all of the Plan's four lines of business: Blue Cross, Blue Shield, Medicare Part A and Medicare Part B (referred to here as "Part B").

HCFA's revision of signature requirements for Part B claims processing in July 1975 further aided the automated system, and allowed additional claims volume to be added to the system. Remote sender locations increased as well as claims receipts, and by the end of 1977, Part B EMC receipts totalled 662,970 or 11.1 percent of the total Part B receipts. At the end of December 1979, 211 remote senders submitted 1,519,137 EMC receipts, an increase of 129 percent over calendar year 1977.

EMC Procedures

Florida BC/BS has identified several essential steps to the successful operation of an automated claims network. Some must be completed prior to the installation of equipment; others can be implemented after the electronic medium is installed.

Procedures Before Installing New Senders: Contacts by inhouse personnel with potential participants are initiated to discuss: how the system works (if the potential sender has never participated, or has no concept of the system); the mode of transmission appropriate to the needs at remote sites; the need for their awareness of the responsibility for meeting HCFA regulations; and, necessity of signed EMC agreements (see **Figures 1-4** at end of article) for all providers submitting at a location. Prior to signing EMC agreements, all providers must meet carrier approval based on utilization review and other screening criteria. Approximately six weeks of review by Florida BC/BS is required before a sender can be approved or denied.

Procedures After Approving Senders and Installing Equipment: Senders must submit Part B test data of approximately 50 claims through the system for review. The data is coded to suspend (in the Medicare

Department) and the suspense documents are thoroughly screened for potential errors. Test data must be 95 percent error free before live claim transmission can begin.

A sender must provide the name of the person responsible for entering and submitting claims data. This name represents a signature, and accompanies the transmittal letter which precedes each claim billing from a sender (see **Figure 5** at end of article). The transmittal letter stipulates that certain conditions will be met at the sender location to satisfy the billing of assigned/unassigned claims as regulated by HCFA, and disclaims any knowledge on the part of the sender of fraudulent misrepresentations through the electronic medium of recording and transmitting data.

A sender must retain a patient's signature on file for all assigned/unassigned Part B claims in accordance with the EMC agreement terms. Of course, for assigned claims, the sender further agrees to accept the Medicare reasonable charge as the full allowable charge.

When both remote sender and the Plan have agreed to all requirements and have carrier as well as corporate approval to transmit claim information, the sender is given a sender code and added to the EMC polling list.

EMC System Overview

All EMC data submitted is common in format for each line of business, regardless of the mode of transmission. However, within this common format, some individualization can still be permitted to the remote senders using the T.I. 742 terminals through specified programming accommodations. These features include:

- Cluster design for common diagnostic/procedure/provider codes which can be activated by one key stroke.
- Constant hard coded data to allow for duplication of fields with minimal key strokes.
- Terminal prompts available as a guide for the operator during entry of claims.

These unique features are not only attractive to the senders but also provide for some online editing which is conducive to data integrity.

When claims entry at the remote sites is complete, the computer-to-computer senders dial the Plan and have the claims data polled. Terminal senders are automatically polled daily, normally after office hours. Confirmation of polled data is returned to the computer-to-computer and terminal senders. Control measures and balancing procedures are also provided to mail in tape senders to ensure data integrity and confirmation of data. In the event a confirmation does not agree with a sender's total, verbal contact can be made to the Plan for further clarification and/or reconciliation, regardless of the mode of transmission.

Upon the receipt of all claims data, including mailed in data, the Blue Shield processing system sorts and splits out the lines of business: Blue Cross, Blue Shield, and Medicare Parts A and B. The Part B data is then passed to the Medicare processing system.

Medicare Part B Processing—Overview: The computer system is designed to edit claims data for completeness of field information, such as proper header records, name field, procedure codes, service dates and money amounts in compliance with HCFA regulations. The system reformats the EMC claims to conform to HCFA-1490 and 1554 formats for Part B processing and generates internal control numbers to ensure data integrity and retrieval measures via computer microfilm. A unique feature of the system in the processing of EMC claims requires that senders/providers must be "Signature On File" (SOF) participants in order for the claims not to suspend for lack of signatures. This is controlled through the signature requirement included in EMC agreements. When the agreements are received in the Medicare department, the senders/providers are updated for SOF on the provider eligibility file. This feature ensures that the carrier screens and approves all EMC participants.

Rejected data from the system's edit/audit features suspend to an analyst who takes corrective measures through the internal system, or by verbal contact with the remote senders to prevent the situation from recurring. This stimulates interest by both parties and results in a greater effort by each to generate error free data.

An important feature of the Part B processing system, the remittance feedback, brings a claim through the full circle of processing. The remittance feedback procedure involves the following steps:

- At the completion of a weekly assigned claims payment/explanation of medical benefits cycle, all EMC claims data are sorted by sender code and recorded to magnetic tape.
- The remittance information is extracted and returned to the computer-to-computer and mail in senders who desire to receive it.

Internal Reviews: For each biweekly claims payment cycle, and for all annually scheduled audits, a one percent claims sample is extracted for EMC senders and reviewed for potential fraud and abuse. Extensive attention is devoted to this sampling in Part B for identification of potential problems. And, if an EMC sender is found to be significantly aberrant, an immediate external audit is set up. If abuse or fraud problems are discovered during the external audit, the Plan's regional office is notified and the sender is removed from the EMC network. These measures are viewed as essential for maintaining Part B claims integrity.

External Audits: Each EMC sender submitting Part B claims is subject to an external audit. For new senders the first audit is 90 days after admittance on the network. Thereafter each sender is scheduled on an annual basis. The audit procedure involves two steps:

- The inhouse Part B department extracts the sender's claims data and reviews it for potential problems, such as overuse of certain procedure codes, modifiers, handling fees, no referring physician, etc. The audit material is then noted if a particular condition exists; this alerts the external auditor of the need for special attention.
- The external auditors conduct onsite audits at the remote senders' locations. Ensuring that proper signatures of patients are maintained for each document of treatment is emphasized. When a sender is found to be in noncompliance with HCFA regulations governing EMC claims processing, recommendations for corrective actions are verbally discussed with the sender and reiterated by letter. The inhouse Part B department is notified of all audit results and must schedule reaudits (90 days later) for the senders found to be in noncompliance. Unsatisfactory results from the reaudits can subject a sender to possible removal from the EMC network, depending upon the severity of the deficiencies.

EMC Performance: In 1979, the average first edit error and additional development percentage for automated claims was under 4 percent as compared to 17 percent for manual claims. This is partially due to the corrective measures used by the carrier to reduce remote site errors. Additionally, periodic recommendations are made to improve the Part B processing system. These recommendations can range from simple manual operations to major program changes (occasionally due to HCFA requirements) in order to maintain optimum data integrity and efficient processing time.

Provider/Carrier Benefits: Since its inception, the automated system of gathering claims data has proved to be advantageous both to the provider and to the Plan's Part B claims operation. Advantages from the system include:

- Better Service—Throughput of claims is faster and more efficient. Approximately 90 percent reach a final disposition without manual intervention.
- Cost Benefits—Provider savings result from fast throughput and cycle time, and program savings occur through reduced administrative costs for claims input and processing. A recent cost benefit study estimates a saving of about $.49 per claim including 100 percent internal reviews and external audit costs.
- Low Claims Development—The integrity of claims data submitted requires less than two percent development for additional information. This low rate is possible because of direct educational feedback to each sender location on a day to day basis.

- Cash Flow—Payment of claims is made on a more timely basis through the realization of relatively error free data.
- Profile Data Integrity—The provider of service is totally responsible for the accuracy of charge data utilized for profile updates. It is not subject to clerical errors on the carrier's part.
- High Claims Processing Quality—This is made possible through strategic system edits, data integrity and minimum manual intervention.

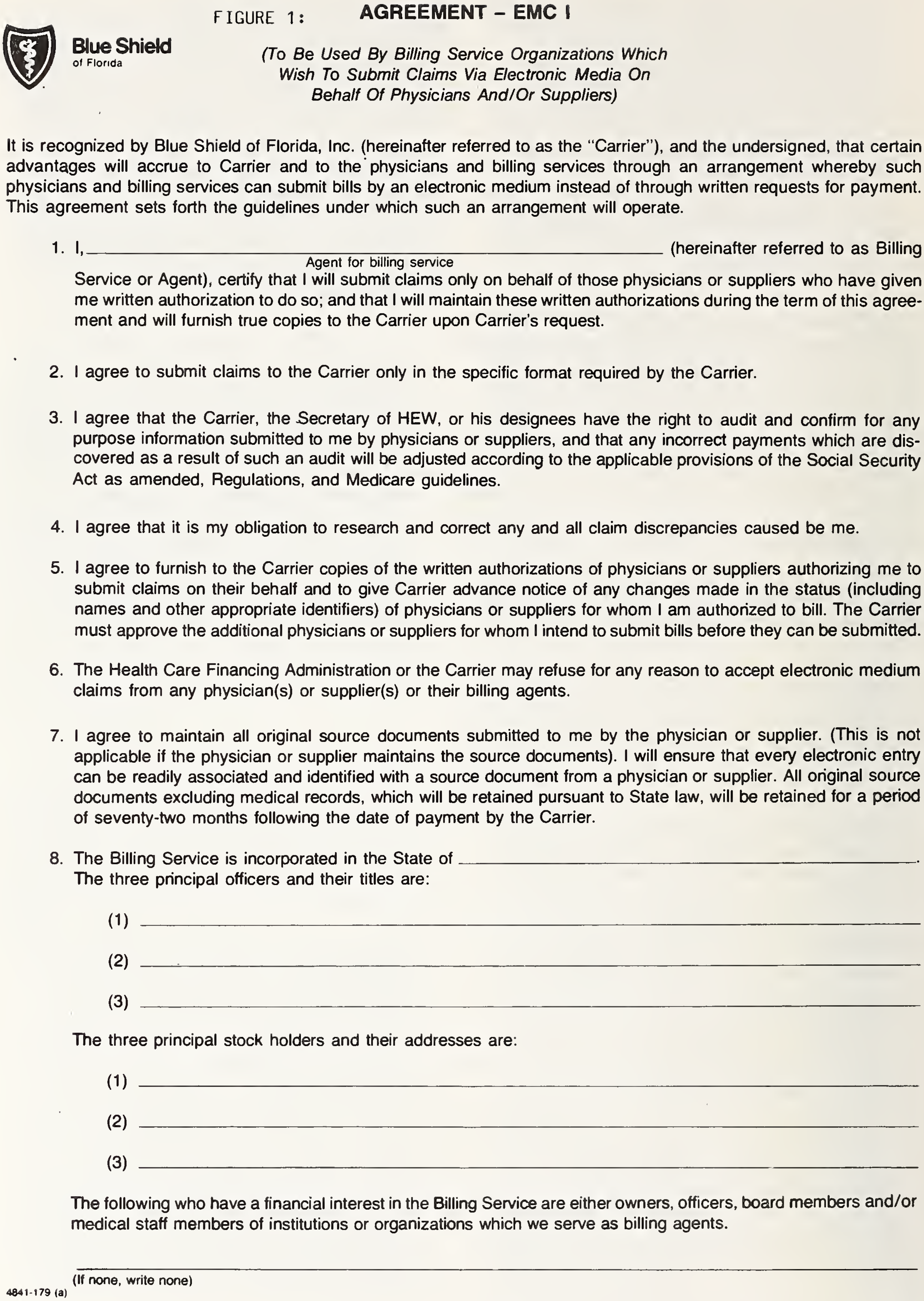
EMC Task Force: From the inception of the EMC network, an active corporate task force has coordinated the activities of multiple functional areas and has resolved any potential conflicts or problems. The task force consists of members from various departments in the Corporation representing all lines of business.

Conclusion

While the emphasis in this article has been on Medicare Part B claims processing, the Plan has recognized similar benefits in all lines of business through the EMC network. Credit for the success of this system must be shared among many corporate personnel: Provider Automated Services, External Software Development, Finance, Claims Processing, EDP Systems, External Audits and Reviews, Provider Relations Divisions, and Medicare Part B. The close cooperation between these several disciplines, while still carrying out their respective duties, has been instrumental in creating an automated network that has become an integral part of the claims processing system.

- *Jacquelyn Adkins, Assistant Manager of Medicare Part B Technical Services, has been with the Florida Plan since 1969. During that time, she has served in various capacities of the Medicare Part B programs. She is chiefly responsible for monitoring and coordinating all of the Medicare Part B EMC functions.*
- *Gwendolyn Cline has been with the Florida Plan for twelve years. During that time she has served in several areas of data processing, including the EMC polling system. For the last two years, she has been a Data Base Analyst in the Medicare Part B program, and has assisted in the development of automating providers for EMC signatures.*

FIGURE 1:



AGREEMENT – EMC I

Blue Shield
of Florida

(To Be Used By Billing Service Organizations Which Wish To Submit Claims Via Electronic Media On Behalf Of Physicians And/Or Suppliers)

It is recognized by Blue Shield of Florida, Inc. (hereinafter referred to as the "Carrier"), and the undersigned, that certain advantages will accrue to Carrier and to the physicians and billing services through an arrangement whereby such physicians and billing services can submit bills by an electronic medium instead of through written requests for payment. This agreement sets forth the guidelines under which such an arrangement will operate.

1. I, ______________________________ (hereinafter referred to as Billing
   Agent for billing service
   Service or Agent), certify that I will submit claims only on behalf of those physicians or suppliers who have given me written authorization to do so; and that I will maintain these written authorizations during the term of this agreement and will furnish true copies to the Carrier upon Carrier's request.

2. I agree to submit claims to the Carrier only in the specific format required by the Carrier.

3. I agree that the Carrier, the Secretary of HEW, or his designees have the right to audit and confirm for any purpose information submitted to me by physicians or suppliers, and that any incorrect payments which are discovered as a result of such an audit will be adjusted according to the applicable provisions of the Social Security Act as amended, Regulations, and Medicare guidelines.

4. I agree that it is my obligation to research and correct any and all claim discrepancies caused be me.

5. I agree to furnish to the Carrier copies of the written authorizations of physicians or suppliers authorizing me to submit claims on their behalf and to give Carrier advance notice of any changes made in the status (including names and other appropriate identifiers) of physicians or suppliers for whom I am authorized to bill. The Carrier must approve the additional physicians or suppliers for whom I intend to submit bills before they can be submitted.

6. The Health Care Financing Administration or the Carrier may refuse for any reason to accept electronic medium claims from any physician(s) or supplier(s) or their billing agents.

7. I agree to maintain all original source documents submitted to me by the physician or supplier. (This is not applicable if the physician or supplier maintains the source documents). I will ensure that every electronic entry can be readily associated and identified with a source document from a physician or supplier. All original source documents excluding medical records, which will be retained pursuant to State law, will be retained for a period of seventy-two months following the date of payment by the Carrier.

8. The Billing Service is incorporated in the State of ______________________________.
   The three principal officers and their titles are:

   (1) ______________________________

   (2) ______________________________

   (3) ______________________________

   The three principal stock holders and their addresses are:

   (1) ______________________________

   (2) ______________________________

   (3) ______________________________

   The following who have a financial interest in the Billing Service are either owners, officers, board members and/or medical staff members of institutions or organizations which we serve as billing agents.

   ____
   (If none, write none)

4841-179 (a)

9. I agree to supply upon request the written particulars of the financial arrangements between me and physicians or suppliers for whom I submit EMC's. This information includes, but is not limited to, my charging practices. I agree to establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from the Department of HEW, or its agents, shall not be used by me, my agents, officers, or employees except as provided in Section 1106 of the Social Security Act, the Freedom of Information Act, and the Privacy Act as amended, and the Regulations prescribed thereunder. I agree not to disclose any information concerning a Medicare beneficiary to any person or organization other than the Secretary of HEW, his designees or agents, and the Carrier without the express written permission of the Medicare beneficiary or his lawful representative.

10. I understand that this agreement may be terminated by me upon 90 days written notice. The Secretary of HEW, his designees or agents, or the Carrier may terminate this Agreement at any time.

11. I understand that the submission of an electronic medium claim is a claim for Medicare payment and that anyone who misrepresents or falsifies any record or other information essential to that claim or that is required pursuant to this agreement may, upon conviction, be subject to fine and imprisonment under Federal Law.

12. Attached to this agreement, and hereby made part of this Agreement, are copies of the Agreements with the individual physicians or suppliers referred to in paragraph 1, above.

13. I understand that this agreement in no way modifies the individual Participating Physician Agreements which physicians who have authorized me to bill for them may have with Blue Shield of Florida, Inc.

14. I shall not knowingly bill Blue Shield of Florida, Inc. in a manner which conflicts with the ethics of the Medical Profession.

15. As further consideration, I agree to submit all Blue Shield and all Medicare claims through the automated process, both assigned and unassigned. Claims requiring additional medical documentation may be submitted separately.

16. If applicable, in consideration of having the use of the Texas Instruments data terminal(s) as provided by Blue Shield of Florida, Inc., I hereby agree to be responsible for cost of replacement of said terminal(s) in event of theft or damage beyond repair and for repairing such terminal(s) when damaged from any cause whatsoever while on premises of said physicians office or physician billing location and to maintain insurance coverage protecting against such loss or damage from any cause whatsoever.

17. I agree that it is my obligation to research and correct any and all billing discrepancies caused by me and agree to hold Blue Shield of Florida, Inc. harmless for any costs or damages incurred as a result of such discrepancies.

18. If applicable, in consideration of having the use of a Texas Instruments data terminal, I agree to be responsible for all moving and relocation expense after the initial installation.

19. If applicable, the Texas Instruments data terminal may be removed for cause, without notice, as determined by Blue Shield of Florida, Inc.

I have agreed to the above by signing below on this ______ day of ______________________________
in the year ______________.

______________________________ Name of Billing Agent

______________________________ Authorized Officer and Title

4841-179 (b)

FIGURE 2:

Blue Shield
of Florida

CERTIFICATE OF RESPONSIBILITY

EMC II

(To Be Executed Between The Physician Or Supplier and Billing Service)

It is recognized by ______________________________ (hereinafter referred to as the
Billing Service

Billing Agent or Billing Service), that certain advantages will accrue to it and the undersigned physician or supplier through an arrangement whereby the Billing Agent can submit claims on behalf of the undersigned physician or supplier by electronic medium to Blue Shield of Florida, Inc. (hereinafter referred to as the Carrier), rather than by written requests for payment. This agreement between me and the Billing Agent is to be used for the purpose of allowing the Carrier to process claims submitted on my behalf by the Billing Agent. Therefore, the undersigned physician or supplier agrees to the following:

1. I hereby authorize the Billing Agent to submit claims on my behalf, and I hereby warrant that the services have been rendered by me.
2. I agree that the Secretary of HEW, his designee or agent, or the Carrier has the right to audit and confirm any Medicare related information submitted by me, and has access to my Medicare claim documentation records and all records, including medical records, in my office or any other place for that purpose. Any incorrect Medicare payments which are discovered as a result of such an audit will be adjusted according to the applicable provisions of the Social Security Act as amended, Federal Regulations, or Medicare guidelines.
3. I shall not knowingly submit claims which conflict with the Social Security Act as amended, Federal Regulations, or Medicare guidelines.
4. I agree that all original source documents will be maintained. I will ensure that every electronic entry can be associated and identified with a source document. All original source documents will be retained for a period of seventy-two months following the month of payment by the Carrier. Medical records will be retained pursuant to the applicable State law.
5. The Carrier has the right not to accept claims covered by this agreement for any reason.
6. I understand that I am responsible for any Medicare claim submitted on my behalf by the Billing Agent and that I am liable for any subsequent adjustment of that payment.
7. I understand that the submission of an electronic medium claim is a claim for Medicare payment and that anyone who misrepresents or falsifies any record or other information essential to that claim or that is required pursuant to this Agreement may upon conviction, be subject to fine and imprisonment under Federal Law.
8. I agree that Blue Shield of Florida, Inc. has the right to audit and confirm any information submitted by me, and has access to my claim documentation records and all records, including medical records, in my office for that purpose, and that any incorrect Blue Shield payments which are discovered as a result of such an audit will be adjusted according to the applicable provisions of Blue Shield contracts with its subscribers.
9. I agree to obtain the signature of each patient or his/her representative in accordance with the Social Security Act as amended, Federal Regulations, Medicare Guidelines, and the Blue Shield of Florida, Inc. requirements applicable to the submittal of claims through an electronic medium, and I further agree that such signatures will be maintained on file as source documents for seventy-two (72) months. I also agree to comply with all Federal Regulations, Medicare Guidelines, and Blue Shield of Florida, Inc. requirements applicable to my use of, or reference to, the patient's or his/her representative's signature on a provider's record for purposes of submitting an electronic medium claim. The location(s) of these signatures will be ______________________________
(Name of facility or other location)

____

____
Street City State

4842-179 (a)

10. I understand that this agreement between me and ______________________________
is to be used for the purpose of allowing Blue Shield of Florida, Inc. to process claims submitted on my behalf.

I have read and agree to the above by signing below on this ________ day of ________________ , in the year______.

Physician – Supplier Name	Billing service Name
Address	Address
Signature	Signature

4842-179 (b)

FIGURE 3:

Blue Shield
of Florida

AGREEMENT – EMC III

(To Be Used By Physicians Or Suppliers Who Wish To Submit Claims Direct To Medicare Carriers Via Electronic Media)

Sender Code: ____________

It is recognized by Blue Shield of Florida, Inc. (hereinafter referred to as the Carrier) and the undersigned, that certain advantages will accrue to the Carrier, and to the undersigned physician(s) or supplier(s) through an arrangement whereby such claims may be submitted via an electronic medium of submission of written claims. This arrangement between the Carrier and a physician or supplier permits the electronic generation of a claim for professional charges or other services and supplies that will be acceptable to the Carrier as written claims. This agreement is to set forth the guidelines under which an arrangement will operate.

1. I agree to submit claims to the Carrier only in the specific format required by the Carrier.
2. I agree that the Carrier has the right to audit and confirm information submitted by me and has access to all original source documents including medical records. Any incorrect payments which are discovered as a result of such an audit will be adjusted according to the applicable provisions of the Social Security Act as amended, Federal Regulations and Medicare guidelines.
3. I agree that it is my obligation to correct any and all discrepant claims submitted to me.
4. I will ensure that every electronic entry can be readily associated and identified with a source document including patient authorizations and signatures. All original source documents will be retained for a period of seventy-two months following the date of payment by the Carrier. Medical records will be maintained according to the applicable State law. (To be completed if physician or supplier is other than a sole practitioner or a sole proprietorship).
5. The ______________________________ is established in the State of
   (Organization, Clinic, P.A., or Other)
   ______________ (PA # __________). The three principal officers and their titles are:

   (1) ______________________________

   (2) ______________________________

   (3) ______________________________

   The three principal stock holders (if any) and their addresses are:

   (1) ______________________________

   (2) ______________________________

   (3) ______________________________

   Attached to this agreement and hereby made part of this agreement are copies of the authorizations from all partacipating physicians allowing the undersigned to bill on their behalf. (Use in case of clinic.)
6. I understand that the submission of an electronic medium claim is a claim for Medicare payment and that anyone who misrepresents or falsifies any record or other information essential to that claim or that is required pursuant to this agreement may, upon conviction, be subject to fine and imprisonment under Federal Law.
7. I agree that Blue Shield of Florida, Inc., has the right to audit and confirm information submitted by me, and has access to all original source documents including medical records. Any incorrect payments which are discovered as a result of such an audit will be adjusted according to the applicable law, regulations, guidelines and provisions of Blue Shield contracts with its subscribers.
8. I agree that it is my obligation to research and correct any and all billing discrepancies caused by me, and agree to hold Blue Shield of Florida, Inc. harmless for any costs or damages incurred as a result of such discrepancies.
9. Blue Shield of Florida, Inc. may refuse to accept electronic medium claims from any physician or supplier for any reason.

4843-179 (a)

10. I agree to establish and maintain procedures and controls so that no information concerning Medicare Beneficiaries, or any information obtained from the HEW shall be used by me, my agents, officers or employees except as provided in Section 1106 of the Social Security Act, as amended, and the Regulations prescribed thereunder. I agree not to disclose any information concerning a Medicare Beneficiary to any person other than the Social Security Administration, HCFA or Blue Shield of Florida, Inc. without the express written permission of the Medicare Beneficiary or his lawful representative.

11. I understand that this agreement in no way modifies the individual Participating Physician's Agreement which I or physicians who have authorized me to bill for them may have with Blue Shield of Florida, Inc.

12. I shall not knowingly bill Blue Shield of Florida, Inc. in a manner which conflicts with the ethics of the Medical Profession.

13. As further consideration, I agree to submit all Blue Shield and all Medicare claims through the automated process, both assigned and unassigned. Claims requiring additional medical documentation may be submitted separately.

14. I agree to obtain the signature of each patient or his/her representative in accordance with the Social Security Act as amended, Federal Regulations, Medicare Guidelines, and Blue Shield of Florida, Inc. requirements, applicable to the submittal of claims through an electronic medium, and I further agree that such signatures will be maintained on file as source documents for seventy-two (72) months. I also agree to comply with all Federal Regulations, Medicare Guidelines, and Blue Shield of Florida, Inc. requirements applicable to my use of, or reference to, the patient's or his/her representative's signature on a provider's record for purposes of submitting an electronic medium claim. The location(s) of these signatures will be ______________________

Name of Facility of Other Location

____.

Street City State

15. I agree, if other than a Blue Shield Participating Physician, to keep an assignment of benefits form, signed by the patient, on file for all assigned Blue Shield claims submitted. I further agree that these signatures will be maintained on file as a source document, for a period of 72 months.

16. If applicable, in consideration of having the use of Texas Instruments Terminal(s) as provided by Blue Shield of Florida, Inc., I hereby agree to be responsible for cost of replacement of said terminal(s) in event of theft or damage beyond repair and for repairing such terminal(s) when damaged from any cause whatsoever while on the premises of said physicians office or physician billing location and to maintain insurance coverage protecting against such loss or damage from any cause whatsoever.

17. If applicable, in consideration of having the use of a Texas Instruments data terminal, I agree to be responsible for all moving and relocation expense after the initial installation.

18. I understand that this agreement may be terminated by me upon ninety (90) days written notice. The Secretary of HEW, his designees, or Blue Shield of Florida, Inc. may terminate this agreement at any time. If applicable, the Texas Instruments data terminal may be removed for cause, without notice, as determined by Blue Shield of Florida, Inc.

I have agreed to the above by signing below on this __________ day of ________________ in the year________.

______________________________	______________________________
Name of Physician, Supplier, P.A. Group	Authorized Officer For Carrier
______________________________	______________________________
Signature	Signature

4843-179 (b)

FIGURE 4:

Blue Shield
of Florida

Sender Code: ____________

PHYSICIAN BILLING AUTHORIZATION

FORM E

I authorize Blue Shield of Florida, Inc., to make payment to the ____________________

____________________ (PA # __________) group, for services performed by me for patients covered under any Blue Shield contract, Medicare, or any other program for which Florida Blue Shield is the carrier or fiscal intermediary. It is understood that Blue Shield payment to the group in no way changes the responsibilities of Blue Shield or me under my Participating Physician's Agreement.

I, the undersigned, hereby authorize the ____________________ group, to accept on my behalf any assignment made by the patient who receives medical treatment from me of the amount payable to such individual under Part B of Title XVIII of the Social Security Act or under any private Blue Shield contract and to receive on my behalf any payments which may be made pursuant to such assignment.

Name (Signature)	Name (Printed)	Blue Shield Number	Date

4845-179

FIGURE 5: Certification Statement

HDR

HEADER

CERTIFICATION STATEMENT

ASSIGNED:	I request payment for the assigned claims included in this transmission. I certify that the services submitted and referenced by this transmission were rendered by me and that the patient authorization and signatures are on file at the location indicated in the agreement and are maintained for each claim submitted by me. I agree to accept the reasonable charge as full charge for the services on the assigned claims.
UNASSIGNED:	I request payment to be made to the specified enrollee on the unassigned claims included in the transmission. I certify that the services submitted and referenced by this transmission were rendered by me and that the patient authorization and signatures are on file at the location indicated in the agreement and are maintained for each claim submitted by me.
BILLING SERVICE: PHYSICIAN AGENT	I hereby certify that the claims submitted in this transmission accurately reflect and represent claims information furnished me by the physician, clinic, or other supplier whom I am representing.

NOTICE: Anyone who misrepresents or falsifies essential information requested by this electronically produced data may upon conviction be subject to fine and imprisonment under Federal Law.

NAME:

A UNIFIED MEDICARE/MEDICAID PROGRAM: THE OKLAHOMA EXPERIENCE

by BERTHA M. LEVY, M.D.*

Introduction

After 13 years' experience as the nation's only State agency Medicare Part B carrier, the Oklahoma Department of Human Services (DHS) has confronted and resolved complex and frustrating problems to establish a unified Medicare/Medicaid program that we believe is beneficial to recipients and convenient for providers. We also believe this experience can be effectively used to plan and develop the Health Care Financing Administration's future operating strategy for program administration.

In this article, we shall briefly describe our experiences and the development of our role as a Medicare carrier. This experience is valuable because Oklahoma has been able to integrate Medicare and Medicaid claims processing by recognizing the significant areas of functional similarity in the programs and the need for compatibility of information. As a carrier, the Oklahoma DHS applies Medicare coverage and reimbursement guidelines to the Medicaid program, where applicable. For example, payment is made only to Medicare approved hospitals; by-pass surgery for obesity is allowed only if there is another condition aggravated by the obesity; payments to certified registered nurse anesthetists are in accordance with Medicare regulations; and services covered by Medicaid are paid at the same reasonable charge as paid by Medicare. The DHS serves as carrier for approximately 48,000 Medicare beneficiaries who are also Medicaid recipients. In FY 1980, we processed about 283,000 Medicare Part B claims and paid $13,114,000 for Medicare Part B services.

Recognizing the benefits of an integrated program, we encouraged other States to consider adoption of a similar program as early as the first State Medicaid directors' meeting in 1967. This article outlines the advantages of a coordinated Medicare-Medicaid claims process for beneficiaries-recipients, for providers, and for State and Federal program administrators.

The Beginning—Challenge and Change

DHS' medical claims processing began in 1957 with the Medical Care program (PL 84-880, the first Kerr-Mills bill). Significant expansion of this activity occurred with the Social Security Amendments of 1965 which introduced Medicaid (Title XIX) and Medicare (Title XVIII). Implementing Medicaid on January 1, 1966, Oklahoma was one of only six States to initiate the program at this earliest possible date. Since the Medicare Part B medical insurance monthly premium can be paid by States for certain Medicaid recipients, Oklahoma elected to "buy in" with Medicare for the categorically needy, effective July 1, 1966. State buy-in also requires State payment of the Part B medical insurance deductible and coinsurance for eligible Medicaid recipients. The Oklahoma Medicare carrier, Aetna, determined beneficiary Part B entitlement, the coverage and reasonable charge for medical services received, and paid 80 percent of the determined reasonable charge. For the Medicare beneficiary who was also a buy-in Medicaid recipient, Aetna advised both the service provider and DHS of the Part B payment and the provider billed DHS for any unmet deductible and the 20 percent coinsurance. DHS then processed and paid the provider the deductible/coinsurance portion of the Part B "crossover" claim.

Despite years of Federal planning for the hospital insurance (Part A) provision of Medicare, the medical insurance (Part B) portion of Medicare was not incorporated into the final Congressional bill until a few months before passage in July 1965. Therefore, significant issues were still unresolved on July 1, 1966 when the Medicare program became effective and DHS started processing Part B crossover claims.

Problems common to all Medicare carriers and premium buy-in agencies caused administrative and operational headaches as the program took shape. The unanticipated volume and complexity of the claims, illegible handwritten claims, and poor carbon copies resulted in delayed processing. The Social Security Administration, responsible for establishing and maintaining centralized computer records for all Medicare beneficiaries, had difficulty providing carriers with prompts, understandable responses to Part B deductible status queries.

Delayed transfer of crossover claims information from Aetna to DHS and our difficulty in matching claims for the Part B deductible/coinsurance with the Aetna prepared Explanation of Medical Payments—sometimes undecipherable because of manual, rather than machine, preparation—caused processing problems for DHS. Many Oklahoma providers, accustomed to submitting claims directly to DHS under the Medical Care program and then under Medicaid, would bill DHS first, until the Medicare deductible was met, then bill Aetna for subsequent claims. This, of course, created confusion and inappropriate claims flow. All of these situations contributed to a growing backlog of crossover claims and by the spring of 1967 DHS had approximately 40,000, or six months', claims on hand.

State Agency as Medicare Carrier

Following a year of growing dissatisfaction with the processing and payment delays created by crossover claims, both the Oklahoma State Medical Association and the Oklahoma State Osteopathic Association suggested that DHS become the Medicare carrier for eligible Medicaid recipients. Carrier status would permit single agency claims processing and payment to providers for beneficiaries/recipients. Acting on this suggestion, DHS applied to the Social Security Administration, Bureau of Health Insurance, to become Medicare carrier for categorically needy recipients, and this contract was awarded effective July 1, 1967. Aetna, of course, remained as Medicare carrier for other Oklahoma beneficiaries.

Initially, DHS was viewed as primarily a welfare agency and was considered somewhat an interloper to the ranks of commercial carriers by the Bureau of Health Insurance (BHI-Medicare). DHS requests and suggestions were frequently ignored and this was particularly evident as the Part B model computer claims processing system for commercial carriers was under development by BHI. The DHS repeatedly requested systems modifications to permit coordination with the Medicaid claims process but systems adjustments were not made. We soon recognized that DHS would have to independently develop a workable, coordinated Medicare-Medicaid claims process.

Coordinated Claims Process

In the course of developing Medicare-Medicaid coordinated programs, Oklahoma introduced numerous operational and procedural "firsts." These include:

1. The first alternative to Form SSA-1490, Request for Medicare Payment, with the development of the DHS' claim Form SSA-1490W (OK) (July 1967): this combined provider billing form allowed single claims for Medicare Part B and Medicaid, reduced the volume of provider paperwork, and facilitated DHS claims processing.
2. The first printed claim form utilizing sensitized paper for carbonless copies (July 1967): the Federal forms had carbon inserts which often produced unsatisfactory copies.
3. The first single payment check written to include the Medicare Part B reasonable charge amount and the applicable

Medicaid deductible and coinsurance amount (1967).

4. The first combined Explanation of Medical Payments (EOMP) which showed both Medicare Part B and Medicaid payments (July 1967): this reduced bookkeeping for providers.
5. The first combined Explanation of Medical Benefits (EOMB) with both Medicare Part B and Medicaid payment: this was a less confusing document for recipients.
6. The first provider profile of reasonable charge utilized by a single fiscal agent for both Medicare and Medicaid: providers recognized that payment by both programs would be under the same reasonable charge screens and this profile gave them an indication of expected payment amounts.

Because of DHS' experience working with and processing medical claims from Oklahoma physicians and other providers, the assignment rate (i.e., acceptance of the Part B reasonable charge determination from DHS as carrier and fiscal agent) has been maintained at more than 96 percent. We recognize that our high assignment rate cannot be accurately compared with the significantly lower assignment acceptance (approximately 50 percent or less) of other carriers who deal with a different beneficiary population. However, it is a favorable result of our carrier status, both to program administration and to beneficiaries.

Many of our accomplishments in Medicare/Medicaid management are due to the efforts of DHS staff offices located in every county in Oklahoma. Each DHS recipient has a local caseworker responsible for their service needs. Each county office maintains Medicaid eligibility information, enhancing the query process by communicating current eligibility data to the claims processing system. In effect since 1969, case information changes are input to the system daily by both the county offices and the State office.

The State agency investigative unit receives and processes complaints from recipients and other concerned citizens and investigating staff research each complaint to resolution. Investigations which result in recoupment from providers who violate the Medicare assignment agreement serve both the program and the beneficiaries.

Providers, working closely with DHS, benefit from the growth and improvements in Medicare and Medicaid program coordination. Such benefits include monthly batch payments which provide a detailed explanation of the Medicare/Medicaid payment for each beneficiary, the reason for payment reduction, or the reason for denial. The monthly batch payment has not only simplified bookkeeping for providers but, because of larger payment amounts, has greatly reduced embezzlement opportunities for provider employees.

Through access to the Medicare Part B reasonable charge screens, DHS is able to make the same payments not only under Medicare and Medicaid, but for other medical service programs administered by DHS, e.g., the Crippled Children's program and the Vocational Rehabilitation program.

Realizing that cooperative provider participation is essential to delivery of beneficiary/recipient medical services, DHS has encouraged providers to communicate concerns and suggestions about the scope of DHS' programs and to assist DHS in developing administrative procedures to expedite the medical claims process. Another benefit for both the providers and DHS occurs when there is a delay in establishing Medicare premium buy-in for eligible recipients. In this situation, the provider is paid promptly by Medicaid, and Medicare funds are subsequently transferred after buy-in status is effectively recorded.

Our agency, in its role as a Medicare Part B carrier, also coordinates with the Medicare Part A hospital insurance intermediary. Intermediary contacts are maintained for proper application of the Part B deductible, appropriate allowance for hospital based ambulance service, continuation of a spell of illness because of a skilled nursing home stay, and coordination of hospital based specialists' contracts and the reasonable charges applicable to those services. Coordination with the Medicare intermediary therefore avoids improper Medicaid payments and provides information about Part A activities, enabling DHS to respond to beneficiary questions.

Conclusion

In reviewing our agency administration and coordination of the Medicare and Medicaid programs for the past 13 years, we believe the Oklahoma DHS has produced innovations in claims operations and processes which benefit all participants in these programs. However, we recognize that more remains to be done.

One of our current projects is a "single stream" claims processing system to allow all non-institutional medical claims (i.e., Medicare Part B, Medicaid, Crippled Children, and Vocational Rehabilitation) to be processed with a single payment check and a single Explanation of Medical Payments for all provided services. This will provide significant improvement in provider bookkeeping, savings to DHS, and more explicit descriptions of all medical services received by recipients. It is anticipated that the "single stream" system will be implemented in the fall of 1981.

We have identified and described some of the benefits experienced with an integrated Medicare and Medicaid claims process administered by a single State agency. We continue to recommend that other States consider such a system.

ACKNOWLEDGEMENTS

*The author wishes to express special gratitude to the supervisory staff of the medical units, and especially Dickye B. Mines and Colleen Stanton, for their help in developing this article.

Bertha M. Levy, M.D., has been Administrative Assistant, Supervisor, of Medical Units for Oklahoma's Department of Human Services, since 1966. A graduate of Tulane University School of Medicine, she is a Clinical Professor of Pediatrics at Oklahoma Univesity School of Medicine.

THE INDIANA CLAIM AND BILL THRUPUT ANALYSIS REPORT

by JON R. HERBOLD

Introduction

State Medicaid agencies readily understand the importance of quickly processing and paying bills submitted to them by the numerous providers who give services to Medicaid recipients. Billing thruput, the time it takes bills to pass through predetermined steps in the adjudication process, has a significant impact on provider relations, and, consequently, on their satisfaction with the Medicaid program. One can reasonably expect providers to be dissatisfied with the program if they are not reimbursed quickly for services they've rendered in good faith; slow payment also seriously impacts on providers' cash flow. The bottom line is that providers may reduce or curtail their future participation in the Medicaid program as a direct result of thruput problems.

Another compelling reason for States to be concerned with thruput problems is that the Health Care Financing Administration (HCFA) has established minimum thruput standards with which States must comply in order to meet MMIS (Medicaid Management Information System) certification requirements and receive increased Federal funding. Failure to meet these standards could result in reduced Federal Financial Participation (FFP) from 75 to 50 percent. This reduction in FFP can result in an increase in State financial obligations of up to several million dollars annually.

States with thruput problems must also contend with intrastate administrative and legislative pressures brought by organized provider groups. Representatives of these special interest groups maintain close liaison with elected and appointed State and Federal officials, and can exert pressure against a State Medicaid agency for failing to reimburse them promptly for services they've provided.

The House Ways and Means Committee recognized the implications of thruput problems when it reported that:

> Undue delays in Medicaid claims payments contribute to the rise of factoring arrangements as well as discourage physicians from participating in the program (H, Report 95-393, Part 1 at 45).

One can readily recognize, therefore, that thruput problems can seriously jeopardize provider participation. That which jeopardizes provider participation jeopardizes the ability of the Medicaid program to meet its objective simply because the program cannot function without sufficient numbers and types of providers to render services to eligible recipients.

This article describes one of Indiana's methods for better overseeing its claims payment process, the "Claim and Bill Thruput Analysis Report." It is one means for us to identify potential problems quickly enough to allow problem intervention.

Background

On May 25, 1979, HCFA promulgated 42 CFR 447.45 and transmitted it to State agencies in HCFA-AT-79-50 (MMB). This regulation established thruput standards for "clean" claims, and further, provided guidelines and options for defining critical terms. Before proceeding we need to explain how and why Indiana defined certain terms somewhat differently, and, in some cases, more stringently than the regulation required. It has always been Indiana's goal to achieve consistency in defining terms throughout its Management and Reporting Subsystem (MARS, subpart of IMMIS, Indiana Medicaid Management Information System). Consequently, Indiana defines a "bill" and a "claim" in much the same way as does the Medicaid Minimum Data Set (MMDS).

Indiana defines a "bill" as each separate billing. With the exception of certain pharmacy billings, this means that each separate sheet of paper is a bill. Pharmacy billings for legend and nonlegend drugs are exceptions since ten separate billings are allowed on one document. Each of the ten separate pharmacy billings is defined as a "bill." Indiana defines a "claim" as each separate line item within a "bill."

42 CFR 447.45 defines a "clean claim" as "one that can be processed without obtaining additional information from the provider of service or from a third party." Rather than developing and maintaining a complex list of error and rejection codes to support this definition, Indiana has operationally defined a "clean claim" as one which has been paid. This definition exceeds the minimum definition in the regulation. See **Figure 1** for a partial list of Indiana's definitions of these and other terms used in this process.

FIGURE 1: Definition of Terms

Term	*Definition*
15 days	Claims or bills processed between zero and 15 calendar days.
30 days	Claims or bills processed between zero and 30 calendar days.
45 days	Claims or bills processed between zero and 45 days.
60 days	Claims or bills processed between zero and 60 days.
90 days	Claims or bills processed between zero and 90 days.
180 days	Claims or bills processed between zero and 180 calendar days.
365 days	Claims or bills processed between zero and 365 calendar days.
365 plus	All claims or bills that were "processed."
average days	The number of "processed" calendar days divided by the number of claims or bills.
Bill	Each separate billing, or sheet of paper, submitted to Medicaid for reimbursement for services with a separate internal control number (ICN). Pharmacy billings are the exception since each "line item" receives its own ICN; therefore, pharmacy or drug billings have the same definition for a "bill" and a "claim."
Claim	Each separate "line item" contained within a "bill."
Clean	Loosely defined as "any claim or bill that is paid."
All Claims or All Bills	All claims or bills regardless of the presence of an error.

42 CFR 447.45 also defines thruput requirements for clean claims:

> "These regulations set time limits for Medicaid agency payment of claims from practitioners who are in individual or group practice or who practice in shared health facilities. For these providers, an agency must pay—
> (1) 90 percent of all clean claims within 30 days of the date of receipt; and,
> (2) 99 percent of all clean claims within 90 days of the date of receipt."

The regulation clearly implies that HCFA is primarily concerned that States comply with the thruput time frame requirements. State agencies, however, are left to their own devices to implement management techniques to ensure that they are within the thruput tolerance limits. State agencies have two options available to ensure compliance.

Options to Achieve Compliance

The first option, *crisis intervention,* is based on the premise that corrective action is appropriate only when there is imminent danger of violating the regulation. While one must be aware of this option, I reject this as a primary management technique. This philosophical tenet, like radical surgery, is indicative of a very serious problem which may have critical repercussions.

The second option, *problem intervention,* is based on the premise that corrective action should be taken before a crisis develops. I support this option since countermeasures based on problem intervention are more constructive and much less administratively disruptive. This philosophical tenet, therefore, is similar to preventive medicine. As one can imagine, the problem intervention process is more complicated; there are several variables which must be considered.

First, one must develop a statistical base which will provide trend information. This pattern must be sensitive enough to be usable for regression analysis; yet, there must be sufficient evidence to desensitize the data from aberrant information. For example, provider billing cycles may cause aberrations for only a few months of the year.

Second, one must be able to identify the magnitude of the problem in order to develop countermeasures. For example, a countermeasure which addresses problems specific to a given provider type may not be appropriate if all providers are experiencing the same problem. Consequently, the statistical base should minimally provide data by the type of billing form and the type of provider.

Third, one must be able to track billings throughout the static points of the thruput process defined in **Figure 2**.

Effective countermeasures may be developed by the agency by recognizing the interrelations of these variables and effecting changes in them. For example, operational improvements could be easily developed if the time required to produce checks is abnormally high, i.e., too many days between the adjudication date and the check date.

FIGURE 2: Static Points in Thruput Process

Last SVC (Service) Date	The most recent service date on the bill or claim.
Billing Date	The date the provider completed the billing form.
Receipt Date	The date the bill was received by the Medicaid agency.
ADJ (Adjudication) Date	The date of the final decision to pay or deny payment for the bill or claim.
Check Date	The date a check was produced as reimbursement for services on the bill or claim.

Implementation of the Claim and Bill Thruput Analysis Report

Based on the understanding of the evidentiary requirements to be in HCFA-AT-79-50, we developed a reporting methodology to comply. It also satisfies the problem intervention measures discussed already.

The *Claim and Bill Thruput Analysis Report* is divided into two broad analytical sections: *type of bill* and *type of provider.* The following briefly describes the organization of the report.

Section One—Analysis Based on Type of Bill: This section has seven pages and provides an analysis based on the *type of bill* submitted, i.e., inpatient hospital, outpatient hospital, drug, medical, and Medicare crossover. **Figure 3** describes these types of bills.

Table 1, at end of article, is an example of the first page of the report. Section One distinguishes between clean bills and all bills, as well as clean claims and all claims. Each of the seven pages provides an analysis based on different adjudication points: 1) last service date to check date; 2) last service date to adjudication date; 3) last service date to receipt date; 4) last service date to bill date; 5) billing date to receipt date; 6) receipt date to adjudication date; and, 7) receipt date to check date. For example, **Table 1** shows an analysis of the time between the last service date and the check date for clean bills and all bills and clean claims and all claims. It shows that Indiana takes an average of 58 days to process clean medical bills from the last service date to the check date. Of the 58 days, page 4 of the report would show that the provider takes about 14 days to complete the billing form, i.e., the last service date to billing date. Page 5 would show a 17 day lapse from the billing date until it is received by Medicaid. The Indiana Medicaid agency takes 25 days to pay the provider from the time the bill is received.

Section Two—Analysis Based on Type of Provider: This section of the report provides an "all claims" analysis based on institutional and noninstitutional *type of provider.* (**Figures 4 and 5** identify the providers included in each category.)

Section Two is similar to the Section One analysis except that thruput points are identified as subcategories of each provider type. This section is vital for determining exactly where and to what extent a thruput problem is occurring. It also assists analysts in determining why a problem exists. In the Section One discussion, it was shown that 58 days are required to process clean medical billings. At that point in the analysis, one could reasonably conclude that there may be a problem with the billing form itself, e.g., the form is too complicated, the instructions for completing the form are ambiguous, etc. Section Two analysis, however, tends to disprove a problem with the form itself.

FIGURE 3: Types of Bills

Term	*Definition*
Inpatient Hospital Billing Form	Used by chronic and acute institutional facilities for inpatient services (e.g., hospitals, nursing homes, etc.).
Outpatient Hospital Billing Form	Used by hospitals for outpatient services.
Drug Billing Form	Used by pharmacists for legend and non-legend drugs.
Medical Billing Form	Used by all other provider types, or for all other services not identified above.
Medicare—Crossover Billing Form	Used for billings received from Medicare as a result of the crossover process.

FIGURE 4: Institutional Providers

The processing cycle for institutional provider types is contained on pages 8 through 11 of the report. Institutional provider types are:

1. Home Health Agencies
2. General Hospitals
3. General Hospitals with Nursing Home
4. Psychiatric Hospitals
5. Skilled Nursing Homes
6. Intermediate Care Nursing Homes
7. Intermediate Nursing Homes for the Mentally Retarded
8. Skilled-Pediatric Nursing Homes
9. Intermediate-Inclusive Nursing Homes
10. Residential Care Facilities

FIGURE 5: Service, Supply, and All Other Providers

The processing cycle for all claims, excluding Medicare crossover claims, for service providers is contained on pages 12 through 18. The provider types are:

1. Audiologists
2. Chiropractors
3. Christian Science Sanitoriums
4. Independent Clinics
5. Outpatient Psychiatric Clinics
6. Dentists
7. Dispensing Opticians
8. Family Planning Agencies
9. Health Maintenance Organizations
10. Independent Labs and X-rays
11. Community Mental Health Centers
12. Private Nurses
13. Optometrists
14. Osteopaths
15. Pharmacists
16. Physicians
17. Podiatrists
18. Psychologists
19. Transportation, Medical
20. Independent Physical Therapists
21. Independent Speech Therapists

The processing cycle for all claims, excluding Medicare crossover claims, for services providers is contained on page 19. The provider types are:

1. Medical Equipment Supplies
2. Prosthetic Device Supplies
3. Hearing Aid Dealers

The processing cycle for all claims, excluding Medicare crossover claims, for providers not specified above, is shown on page 20.

Table 2, at end of article, is an example of page 17 in Section Two of the report; it analyzes thruput for physicians', podiatrists', and psychologists' billings. Under the heading "physicians" on **Table 2**, one can see that there is an average of 75 days between the last service date to the check date. It also shows an average of 49 days between the last service date and the receipt date. A recent analysis of the causes shows that the 49 day lapse between the service date and the date of receipt by the Medicaid agency is the result of providers' billing third parties prior to billing Medicaid. Further, another 26 days is required to adjudicate and pay the claims, and this is really the only time period a State Medicaid agency controls. Since Indiana operates under the cost avoidance principle, the 26 day lapse is required to ensure that third party payments are exhausted prior to a payment by Medicaid. The 49 days are more directly controlled by the providers.

The earlier discussion of **Table 1**, which described the Section One analysis, identified a potential problem area, and the discussion of Section Two identified a provider type, i.e., physicians, which significantly contributed to the problem. Further analysis identified the cause. Countermeasures which will decrease the thruput time while still maintaining the integrity of the third party liability cost avoidance principle are currently being developed.

Conclusion

Indiana produces the report each month and reviews it to isolate significant problems. If such problems are identified, we recommend further analysis and research.

The report can also be used to show providers where specific gaps occur, some of which are directly their responsibility.

An understanding of this thruput report enables one to develop effective countermeasures by providing direction toward the most important questions that must be answered. Indiana's use of this report led to an extensive review of the billing form itself and the various edits used in the computerized claims processing system. As a result of this analysis, the billing form is being revised; a new coding scheme will be used to inform providers of third party insurance coverage; and, the system edits are undergoing extensive review. It is anticipated that these illustrative countermeasures will result in a faster adjudication process while increasing the integrity of the overall system.

After examining the report carefully, the reader will recognize its subtlety. This is a highly complex report which provides both a general overview and a detailed analysis. The report is useful for crisis and problem intervention. One will also see that the balancing of information in one part of the report with information in another part is extremely delicate.

ACKNOWLEDGEMENTS

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Jon Herbold has been a Medicaid systems analyst for two years, and has worked with HCFA Central Office in developing the reporting methodology used in the Medicaid Minimum Data Set (MMDS). He has designed numerous reports to increase the efficiency as well as potentially reduce the cost of the Indiana Medicaid program. Mr. Herbold developed and refined the technical specifications for Indiana's latest Request for Proposal for Fiscal Agent services for the period 1982-1984. He is also a member of the Systems Technical Advisory Group (S-TAG).

TABLE 1:

WM06-08R

INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
BILL & CLAIM PROCESSING THRUPUT ANALYSIS

DATE 08/23/80
PAGE 1

TYPE OF BILL LAST SVC DATE-CHECK DATE	15 DAYS	30 DAYS	45 DAYS	60 DAYS	90 DAYS	180 DAYS	365 DAYS	365 PLUS	AVG. DAYS
CLEAN BILLS (UNIQUE ICN)									
INPATIENT HOSPITAL	31.2245%	77.8369%	85.7414%	89.2933%	92.7516%	97.6172%	99.7376%	100.0000%	
	9,042	22,540	24,829	25,859	26,859	28,268	28,882	28,958	35
DRUG (SAME AS CLEAN CLAIMS	5.8145%	61.0539%	83.6433%	91.0791%	95.7411%	98.9307%	99.9729%	100.0000%	
	21,022	220,738	302,409	329,293	346,148	357,680	361,448	361,546	35
MEDICAL	.0209%	10.3607%	54.1483%	73.5839%	88.2938%	97.0026%	99.8129%	100.0000%	
	20	9,910	51,793	70,383	84,453	92,783	95,471	95,650	58
OUTPATIENT HOSPITAL	.1974%	31.2789%	55.3396%	67.8142%	76.2724%	95.2434%	99.6792%	100.0000%	
	32	5,070	8,970	10,992	12,363	15,438	16,157	16,209	64
MEDICARE CROSSOVER	.0000%	5.0163%	41.7506%	64.6756%	82.3936%	94.2247%	99.3779%	100.0000%	
	0	1,395	11,610	17,985	22,912	26,202	27,635	27,808	70
TOTAL	5.6804%	48.9753%	75.3740%	85.7293%	92.9389%	98.1515%	99.8910%	100.0000%	
	30,116	259,653	399,611	454,512	492,735	520,371	529,593	530,171	
ALL BILLS (UNIQUE ICN)									
INPATIENT HOSPITAL	30.3578%	75.6593%	83.7750%	87.5053%	91.1966%	96.7531%	99.3448%	100.0000%	
	9,359	23,325	25,827	26,977	28,115	29,828	30,627	30,829	39
DRUG (SAME AS ALL CLAIMS)	5.5541%	59.2699%	82.1237%	89.8490%	94.8177%	98.4558%	99.8501%	100.0000%	
	21,120	225,378	312,281	341,657	360,551	374,385	379,687	380,257	37
MEDICAL	.0188%	9.6026%	51.6255%	71.3582%	86.3919%	95.9119%	99.3759%	100.0000%	
	20	10,232	55,009	76,035	92,054	102,193	105,889	106,554	63
OUTPATIENT HOSPITAL	.1873%	29.5025%	53.7030%	66.0515%	74.9215%	94.0169%	99.1461%	100.0000%	
	34	5,355	9,748	11,989	13,599	17,065	17,996	18,151	68
MEDICARE CROSSOVER	.0000%	4.9498%	40.9445%	63.5306%	81.1635%	93.1957%	98.6947%	100.0000%	
	0	1,460	12,077	18,739	23,940	27,489	29,111	29,496	74
TOTAL	5.4013%	47.0115%	73.4038%	84.0983%	91.6807%	97.4664%	99.6503%	100.0000%	
	30,533	265,750	414,942	475,397	518,259	550,965	563,310	565,287	
CLEAN CLAIMS (UNIQUE LINE ITEM)									
INPATIENT HOSPITAL	21.0888%	62.4707%	74.9136%	80.2025%	85.9968%	95.4040%	99.5158%	100.0000%	
	12,935	38,317	45,949	49,193	52,747	58,517	61,039	61,336	49
DRUG	5.8145%	61.0539%	83.6433%	91.0791%	95.7411%	98.9307%	99.9729%	100.0000%	
	21,022	220,738	302,409	329,293	346,148	357,680	361,448	361,546	35
MEDICAL	.0118%	8.8251%	47.3858%	66.4164%	83.4858%	95.6333%	99.6718%	100.0000%	
	21	15,701	84,306	118,164	148,533	170,145	177,330	177,914	65
OUTPATIENT HOSPITAL	.1340%	30.3042%	54.8385%	67.8997%	76.4710%	95.3927%	99.6917%	100.0000%	
	40	9,044	16,366	20,264	22,822	28,469	29,752	29,844	64
MEDICARE CROSSOVER	.0000%	5.1212%	40.9204%	63.7004%	81.7400%	93.5353%	98.8041%	100.0000%	
	0	3,019	24,123	37,552	48,187	55,140	58,246	58,951	73
TOTAL	4.9331%	41.5926%	68.6136%	80.4051%	89.6817%	97.1519%	99.7425%	-100.0000%	
	34,018	286,819	473,153	554,466	618,437	669,951	687,815	689,591	
ALL CLAIMS (UNIQUE LINE-ITEM)									
INPATIENT HOSPITAL	20.2787%	59.8514%	72.4381%	77.8923%	83.9253%	94.0774%	98.8155%	100.0000%	
	13,593	40,119	48,556	52,212	56,256	63,061	66,237	67,031	55
DRUG	5.5541%	59.2699%	82.1237%	89.8490%	94.8177%	98.4558%	99.8501%	100.0000%	
	21,120	225,378	312,281	341,657	360,551	374,385	379,687	380,257	37
MEDICAL	.0103%	8.0793%	44.6747%	63.7932%	81.1124%	94.2163%	99.1667%	100.0000%	
	21	16,443	90,922	129,832	165,080	191,749	201,824	203,520	71
OUTPATIENT HOSPITAL	.1346%	28.5137%	53.2310%	66.1312%	75.0673%	94.1752%	99.1354%	100.0000%	
	45	9,531	17,793	22,105	25,092	31,479	33,137	33,426	68
MEDICARE CROSSOVER	6.3331%	50.8483%	74.2030%	83.7242%	90.5979%	97.0335%	99.5398%	100.0000%	
	34,758	279,073	407,252	459,507	497,232	532,553	546,308	548,834	46
TOTAL	5.6393%	46.2703%	71.1083%	81.5294%	89.5499%	96.7690%	99.5235%	100.0000%	
	69,537	570,544	876,814	1,005,313	1,104,211	1,193,227	1,227,193	1,233,068	

TABLE 2:

WM06-09R

INDIANA MEDICAID MANAGEMENT INFORMATION SYSTEM
ALL CLAIM (UNIQUE LINE ITEM) PROCESSING THRUPUT ANALYSIS
MEDICARE CROSSOVERS NOT INCLUDED

DATE 08/23/80
PAGE 17

SERVICES PROVIDERS	15 DAYS	30 DAYS	45 DAYS	60 DAYS	90 DAYS	180 DAYS	365 DAYS	365 PLUS	AVG. DAYS
PHYSICIANS									
LAST SVC DATE - CHECK DATE	.0124%	8.6198%	44.2021%	62.7489%	78.8403%	92.5823%	98.9066%	100.0000%	
	14	9,752	50,008	70,991	89,196	104,743	111,898	113,135	75
LAST SVC DATE - ADJ DATE	.1856%	21.0678%	52.4029%	67.3735%	80.5904%	93.0534%	98.9826%	100.0000%	
	210	23,835	59,286	76,223	91,176	105,276	111,984	113,135	69
LAST SVC DATE - RCPT DATE	29.6902%	59.4263%	71.1955%	78.1535%	85.3193%	94.5269%	99.4193%	100.0000%	
	33,590	67,232	80,547	88,419	96,526	106,943	112,478	113,135	49
LAST SVC DATE - BILL DATE	64.4900%	76.6084%	82.2870%	85.9512%	90.1969%	96.2482%	99.6433%	100.0000%	
	72,864	86,556	92,972	97,112	101,909	108,746	112,582	112,985	31
BILLING DATE - RCPT DATE	62.8037%	86.8988%	92.7229%	95.2252%	97.1415%	99.3883%	99.9328%	100.0000%	
	71,053	98,313	104,902	107,733	109,901	112,443	113,059	113,135	19
RECEIPT DATE - ADJ DATE	14.5181%	90.7544%	97.5737%	99.2779%	99.8701%	100.0000%	100.0000%	100.0000%	
	16,425	102,675	110,390	112,318	112,988	113,135	113,135	113,135	20
RECEIPT DATE - CHECK DATE	2.1806%	83.6266%	95.8457%	98.7926%	99.8462%	100.0000%	100.0000%	100.0000%	
	2,467	94,611	108,435	111,769	112,961	113,135	113,135	113,135	26
PODIATRISTS									
LAST SVC DATE - CHECK DATE	.0000%	18.4315%	62.9379%	75.9554%	87.1417%	96.6959%	99.6019%	100.0000%	
	0	463	1,581	1,908	2,189	2,429	2,502	2,512	57
LAST SVC DATE - ADJ DATE	.0000%	40.0080%	69.7452%	80.0159%	87.8981%	96.9347%	99.6019%	100.0000%	
	0	1,005	1,752	2,010	2,208	2,435	2,502	2,512	51
LAST SVC DATE - RCPT DATE	51.9506%	77.3089%	83.8376%	87.6990%	92.3567%	97.8105%	99.6417%	100.0000%	
	1,305	1,942	2,106	2,203	2,320	2,457	2,503	2,512	31
LAST SVC DATE - BILL DATE	76.9323%	86.4940%	89.8008%	91.3944%	94.9402%	98.4861%	99.8008%	100.0000%	
	1,931	2,171	2,254	2,294	2,383	2,472	2,505	2,510	18
BILLING DATE - RCPT DATE	82.9618%	94.3869%	96.4172%	97.3328%	98.7261%	99.6815%	100.0000%	100.0000%	
	2,084	2,371	2,422	2,445	2,480	2,504	2,512	2,512	13
RECEIPT DATE - ADJ DATE	19.3471%	89.4506%	97.0939%	99.5621%	99.9602%	100.0000%	100.0000%	100.0000%	
	486	2,247	2,439	2,501	2,511	2,512	2,512	2,512	21
RECEIPT DATE - CHECK DATE	.3583%	82.7627%	95.8201%	98.6863%	99.9602%	100.0000%	100.0000%	100.0000%	
	9	2,079	2,407	2,479	2,511	2,512	2,512	2,512	27
PSYCHOLOGISTS									
LAST SVC DATE - CHECK DATE	.0000%	3.8732%	20.2465%	38.2042%	61.6197%	89.9648%	99.4718%	100.0000%	
	0	22	115	217	350	511	565	568	100
LAST SVC DATE - ADJ DATE	.0000%	6.8662%	27.2887%	46.6549%	65.1408%	90.8451%	99.4718%	100.0000%	
	0	39	155	265	370	516	565	568	95
LAST SVC DATE - RCPT DATE	11.6197%	33.8028%	51.7606%	60.5634%	71.8310%	94.0141%	99.6479%	100.0000%	
	66	192	294	344	408	534	566	568	75
LAST SVC DATE - BILL DATE	38.2042%	54.7535%	59.5070%	66.0211%	75.0000%	95.2465%	99.6479%	100.0000%	
	217	311	338	375	426	541	566	568	61
BILLING DATE - RCPT DATE	66.7254%	93.4859%	97.5352%	99.1197%	99.6479%	99.6479%	100.0000%	100.0000%	
	379	531	554	563	566	566	568	568	14
RECEIPT DATE - ADJ DATE	5.2817%	90.8451%	97.0070%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	
	30	516	551	568	568	568	568	568	21
RECEIPT DATE - CHECK DATE	.8803%	85.3873%	95.7746%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	
	5	485	544	568	568	568	568	568	26

RADAR

Research and Demonstration Activity Report

Congressional Study of Medicare

This report by the Select Committee on Aging, House of Representatives, examines the effectiveness of today's Medicare program. It analyzes Medicare's strengths and weaknesses, and the attitudes of the nation's 24 million senior citizens toward Medicare. It also offers recommendations to resolve identified problems and to strengthen the program. The report contains excerpts from, and is based upon thousands of letters to Congress from senior Americans, previous Medicare hearings and reports, findings from questionnaires sent to senior citizens and providers, and, of course, hearings conducted for this report.

The report indicates senior citizens overwhelmingly believe Medicare has been a success and there is no support among them for its abolishment. However, seniors do feel that Medicare benefits have been shrinking rapidly. There is a growing gap in their perception of what Medicare will cover and what it actually does cover. Many of the elderly mistakenly believe it will cover all, or at least 80 percent, of their health costs. The report indicates that Medicare is paying about 10 percent less of senior citizens' health bills in 1980 than it paid at inception in 1966, when Medicare was paying about 50 percent of the total per capita health care costs of the elderly. After deducting the premiums paid for Part B of Medicare, the program paid only about 40 percent of the 1980 total. The statistics cited also indicate that, as in 1966, seniors pay about 50 percent of their own health bills. The remaining 10 percent is continually being shifted to Medicaid.

The elderly believe that the reduction in Medicare benefits causes them several problems. First, they feel they have been denied benefits promised by Congress. Second, because they are not receiving as many benefits as they believe they need, they are forced onto Medicaid, which they view negatively. They feel it is a form of charity and the services available under Medicaid are often of lesser quality than those provided under Medicare. Third, there has been severe psychological damage to the elderly caused by their perception of Medicare as something worked for and earned, as opposed to the perception that Medicaid is a handout for indigents.

In addition, the elderly see Medicare paying less and less of their health care bills, while it costs them more and more in premiums, deductibles, and coinsurance. They live in fear of getting sick, going broke, going into a nursing home, going on welfare, or becoming dependent on their family.

The primary request made by senior citizens is for Congress to do something to encourage physicians to accept assignment for Medicare Part B costs. All Part A hospital costs are paid directly to the provider of Medicare services. Under Part B, payments can either be made to the beneficiary or to the doctor, if he/she is willing to accept assignment. This is important because Medicare pays about 75 percent of senior citizens' hospital (Part A) costs but only about 55 percent of their doctor (Part B) bills. When a physician accepts assignment, the physician bills Medicare directly and accepts the reasonable charge determination by Medicare as payment in full (with the beneficiary's deductible and coinsurance amounts) for his/her services, even if less than what the physician charged. The committee found that low Medicare reimbursement and red tape have reduced the number of physicians willing to accept assignment, making it increasingly difficult for elderly patients. In 1966, two of every three physicians accepted Medicare assignment. Today, less than one of every two doctors in the program will do so.

To the elderly, the most aggravating part of Medicare is the responsibility they have to bill Medicare when physicians refuse to accept assignment. The elderly feel they are being cheated, not by doctors, but by Medicare. They do not understand the Part B "reasonable charges" concept, as opposed to a doctor's actual charge. All they know is they must pay cash on a $35 bill, fill out forms, wait about two months, and then they may only receive $15 from Medicare, or nothing, if they haven't met the annual Part B deductible.

Recommendations: One of the bills recommended by this report, H.R. 7765, the Omnibus Reconciliation Act of 1980, has been enacted. It includes many provisions which widen beneficiary coverage and remove several barriers to services. For example, it provides for unlimited home health visits (previously limited to 100 visits per year), eliminates the three day prior hospital stay requirement under Part A for home health services, eliminates the $60 deductible for home health benefits under Part B, and provides for new sanctions which can be brought against nursing homes as an alternative to terminating all Medicare and Medicaid payments through decertification.

Another committee recommendation is to repeal the $52 a day deductible applicable under Part A for the 61st through the 90th day of hospitalization. The committee believes this would not be very costly, because very few elderly are hospitalized for 60 consecutive days, and it would help the elderly by eliminating one of Medicare's most confusing provisions.

Tax incentives to encourage physicians to accept assignment are also recommended. The report suggests amendment of the Internal Revenue Codes to allow physicians agreeing to accept assignment from all their Medicare patients and who receive at least $10,000 in Medicare payments to deduct a certain portion of their Medicare receipts from their reportable income.

The committee also recommends the enactment of Federal legislation to increase home health benefits and nursing home coverage, and to cover eyeglasses, hearing aids, biannual physical examinations, dental care, and outpatient prescription drugs, which are not covered under Medicare. It is contended that this could be done through the establishment of a new self financing, voluntary Part C of Medicare which could be funded, in part, by a premium equal to the Part B premium. The additional needed revenues could be raised through a small excise tax on alcohol and tobacco or, if necessary, through general revenues.

Other ways discussed of funding the benefit increases are reducing program fraud and abuse through aggressive fraud detection programs, which could be established in the Justice Department, reducing unnecessary hospital stays, and encouraging alternatives to institutionalization.

Copies of this report, Medicare After 15 Years: Has it Become a Broken Promise to the Elderly? *Report (With Supplemental Views) by the Select Committee on Aging, U.S. House of Representatives, Ninety-Sixth Congress, Second Session, Comm. Pub. No. 96-245, November 17, 1980, are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.*

Health Industry Antitrust Enforcement

This article discusses the recent movement to enforce antitrust laws in the health care sector. Inconsistencies between antitrust authorities' objectives, and current and emerging HHS health policies are pointed out, as is the role organized medicine has played in shaping the economics of medical practice to its liking. The restraints this has placed on the development of the health care financing system are also detailed. Much of the paper deals with several antitrust principles the author believes are needed to reform the medical services industry to break up "anticompetitive combinations."

Efforts to enforce antitrust principles in health care began in earnest in 1975 after the Supreme Court ruled that the "learned professions" are not exempt from antitrust rules. That decision, plus concerns about inflation in health care costs, led to the Federal Trade Commission (FTC) focusing on the health industry. Due to the discovery of many actionable restraints of trade, the FTC has continued its stepped up commitment. The Justice Department's Antitrust Division, though less involved, has also provided advice to the Department. There have also been some significant health care antitrust actions by several States' attorneys general.

Federal antitrust authorities neglected the health sector prior to the 1975 Supreme Court decision for several reasons. They recognized a possible implied exemption for the medical profession, they had doubts concerning their jurisdiction, and they lacked expertise about the industry and its shortcomings. Finally, without close antitrust scrutiny, many anticompetitive practices and institutions became entrenched. They seemed to be natural and beneficial, as they were consistently justified in terms of quality assurance, professionalism, and traditional doctor-patient relations. These established practices and institutions are no longer being accepted by antitrust lawyers skeptical of conventional explanations and justifications for the absence of competition in the health services industry.

The author asserts that the medical profession has reacted with displeasure to current antitrust efforts, which they fear will prove insensitive to the special features of the health industry, particularly the quality of care problem and the profession's self regulatory responsibilities. Although antitrust agencies are leading advocates of deregulation in the economy, there is a trend toward regulating the health sector. Because antitrust law and its underlying policy of competition contemplate neither the perpetuation of the status quo nor an increase in governmental power, they appeal politically as vehicles of major reform. These factors, the author says, seem likely to cast antitrust agencies unwillingly into larger roles than they want, or perhaps can fill.

It is indicated that enforcement agencies are uncertain as to how far or how hard to push regarding market forces. There have been few actions concerning matters that affect quality of care. This situation is expected to continue as antitrust enforcers recognize that significant problems occur when attempts are made to phase competition into a market where it has been absent. In addition, antitrust enforcers might conclude that weakening certain profession sponsored controls would be undesirable until competitive institutions are in place and can assume responsibilities on a more decentralized basis. However, they have to be concerned about the possibility that the existence of such controls may, directly or indirectly, prevent the desired competitive developments.

The antitrust agencies' lack of enthusiasm for the health industry's efforts to police itself lies in the law itself. Now, after the Supreme Court decision, prosecutors are left only limited discretion in evaluating collaborative activities among competitors. It is now presumed that competition is required, whether or not desirable in a particular circumstance, unless Congress or a State legislature has otherwise decreed. However, agencies are allowed discretion to choose their targets (allocate enforcement resources) based on probable gains to the public welfare, the author points out.

The issues in antitrust cases center around whether certain activities have significantly impaired competition with respect to price or output, or have appreciably restrained market entry or competitive innovation. Any self regulatory activities must be justified on the basis that the competitive process is strengthened (e.g., certification and accreditation programs that give consumers reliable information to help them make informed purchase decisions).

The profession's dominant premise for their reforms in the financing and delivery of medical care has been that the public should look to them—the professionals—rather than to individual competitive behavior, for solutions to any existing problems. However, traditional antitrust doctrine rejects the premise that industry wide groups can serve as unbiased arbiters of price, quantity, quality, and other economic matters. Instead, doctrine demands that decisions on such matters be made on a decentralized competitive basis, by producers whose ability to further their own interests is checked by the need to satisfy consumers, even when it is unclear whether market forces can be immediately or totally effective.

Early Enforcement Initiatives: As stated, prior to 1975, antitrust policy in the health industry was negligible and competitive principles were not enforced. After the Supreme Court decision, antitrust prosecutors and economists quickly identified certain practices that seemed worthy of attention. The paper identifies these as "knee-jerk" reactions, not part of a carefully planned strategy, but states the targets were usually reasonable and no important mistakes were made. Most of the enforcement agencies' actions were found "right for the wrong reasons."

One early initiative still under appeal is the FTC's complaints against the AMA and two Connecticut medical societies charging unlawful restrictions on competitive advertising. Competitors who agree not to advertise violate antitrust principles because this could lead to withholding information valuable to consumers.

Antitrust enforcers also began to look for price fixing activities. One such activity concerns professional sponsorship of "relative value studies" (RVS), tables assigning numerical weights to medical procedures to indicate the proportional relation of each procedure to all others on the list. An RVS is not a fee schedule, but can be turned into one by multiplying each item by a dollar conversion factor. A number of RVS have been enjoined or subjected to FTC orders because they have been used to identify and chastise price cutters, and to facilitate overt price fixing. (Explicit fee schedules are illegal.)

Antitrust authorities also considered the medical profession's direct participation in the management of most Blue Shield plans as price fixing and a conflict of interest, because they participate in controlling a plan that sets their fees.

Current Antitrust Enforcement Agenda: Numerous health industry antitrust enforcement actions are discussed and analyzed in this paper. The first actions covered are boycotts and related restraints. A boycott (e.g., concerted refusal to deal with financing plans that adopt cost containment measures which threaten professional interests) is the medical profession's ultimate defensive weapon. Boycotts aimed at physicians or other providers who cooperate with HMOs or other innovative programs often violate antitrust laws, unless the striking providers are employees of the target enterprise and can claim the antitrust exemption granted labor organizations. The FTC recently began filing complaints in cases of this kind. For example, the FTC has charged that a Michigan State medical society has sought to persuade its members to withdraw from an independent Blue Shield plan that undertook "unwanted" cost containment initiatives. Such cases are designed to discourage retaliatory efforts by providers, and encourage third parties who previously feared to offend physicians. Policy statements from professional organizations that inspire boycotts are unlawful because they restrain private innovation and should be subject to sanction, in order to protect consumer interests.

Also discussed is collective bargaining. Medical organizations have long maintained the right to deal as a group with third parties, and to approve or disapprove cost containment measures. Third parties have often accepted these organizations as doctors' bargaining agents because of the fear of boycott or other unpleasantness, should they refuse to do so. The Michigan FTC complaint resulted in the physicians seeking collective negotiations, which the Commission is also attempting to enjoin. Even when voluntary, collective bargaining by groups of competitors not entitled to form an exempt labor organization violates the law. Such bargaining stands in the way of independent initiatives that health care financing plans might take on the consumer's behalf. This stance also forecloses third party efforts to obtain provider services on competitively negotiated terms. Comparable collective bargaining by hospitals with Blue Cross plans over cost reimbursement formulas is cited as "an attractive antitrust target " with the Blue Cross plan being considered a co-conspirator. The author suggests opening the market, particularly large employment groups, to competing plans, perhaps organized by groups of dissatisfied providers, as competition could help protect providers and consumers from exploitation.

Conclusion: The author believes the activities of the organized professions must be opened to antitrust scrutiny, that profession dominated reforms adversely affecting the competitive market for professional services are unlawful, despite their benign purpose and beneficial impact. Although there will be some temporary setbacks in the courts, he feels that most of the medical profession's historic defenses against effective competition should be recognized by the courts as unlawful restraints of trade. The most crucial issues raised are the means by which organized health care providers have systematically restricted private health financing plans to the passive role of third party payor, thus preventing them from acting as purchasing agents for, or in the financial interest of, the consumer. To successfully confront these issues, antitrust enforcers must become fully educated, and, in turn, educate the courts to the importance of vigorous competitive bargaining between health plans and competing providers. Such competitive bargaining should favorably impact on prices and force providers to accept meaningful oversight of their utilization patterns.

The full import of the antitrust effort in the health sector is not yet clear, but the author believes that antitrust law can be established as a succinct check on the medical profession's power to shape its economic environment. Policy can be directed toward the possibility that market forces can prevent unwarranted cost escalation, and can be used to improve consumer choice, and toward the use of private incentives for resource allocation.

Only a small band of antitrust enforcers exist to take on a huge and fragmented industry in which anticompetitive traditions run deep, the writer points out. Because the author believes the amount of antitrust enforcement necessary is so great, he concludes that the FTC will be unable to resolve many existing problems. They may only be able to choose several cases as object lessons, issue staff studies conceptualizing the issues in such areas, and report on the FTC's already extensive inquiries. One objective, he asserts, should be to lay the groundwork for private litigation which could have considerable deterrent power and, in the long run, may be the best mechanism for bringing abuses to light.

Because the enforcement agencies were initially unable to sort out the more important cases from the less important, they made more questionable decisions in deploying their limited resources. The FTC has become more sophisticated and is now able to focus their enforcement priorities more effectively, he goes on. This new focus is on improving competitive conditions so that privately initiated change can occur in the health care financing system, along with the recognition that the traditional forms of private health care financing are not inevitable but were adopted, in part, due to the power of organized medicine. He also believes that private incentives to control costs are strong enough to cause significant change in private financing techniques if innovation is not restrained by provider interests (e.g., physicians) who have a stake in keeping the status quo.

Despite the many obstacles identified, the author views competition in the health care field as a viable idea. HMOs have demonstrated a capacity to provide good care for less money in the private sector. An FTC study suggests that competition from HMOs also serves to stimulate other areas of the private sector to do more to contain costs. In addition, savings realized by HMOs are not due to any particular form of organization, but are the result of the competition HMOs face in setting premiums. Also, FTC antitrust enforcement and advocacy of competition are helping to accelerate private sector changes in health policy.

This paper, "Antitrust Enforcement in the Medical Services Industry: What Does It All

Mean? published in the Milbank Memorial Fund Quarterly, *Volume 58, Number 1, Winter 1980, was supported by Grant Number HS 01539 from the National Center for Health Services Research, U.S. Department of Health, Education, and Welfare. Correspondence may be directed to: Professor Clark C. Havighurst, Director, Program on Legal Issues in Health Care, Duke University School of Law, Durham, North Carolina 27706.*

Group Practice Consulting Patterns

The cost containment possibilities of group practice led an assistant professor of health administration and an information systems designer to study prepaid groups in hospital settings. This 1977 study examined the effect of group practices on informal physican relationships. The researchers reviewed physician patterns of within hospital consultations in two forms of group practice, fee-for-service and prepaid, to gauge how the practice arrangements and structure of each group might affect consulting patterns. The analysis focuses on the frequency and reciprocity with which physicians both requested and rendered consultations within and outside their group.

The study was conducted in a major 550 bed Denver hospital where three categories of physicians practiced: (1) those in major prepaid group practice (PPG); (2) those in major fee-for-service group practice (FFS); and (3) unaffiliated physicians (UA), most in solo practice. In addition, there were a large number of medical residents who were potential consultants for the hospital medical staff. During the course of the study, physicians in the two group practices admitted more than 90 percent of their patients needing such care to this hospital. Several other metropolitan hospitals provided residual, specialty services to the two group practices.

The two group practices differed in how long they existed as a group, how long they were formally affiliated with the hospital, and in their mechanisms for reimbursement. The fee-for-service group was established in 1956, while the prepaid group was not established until 1969. The PPG physicians were paid on a capitation basis plus limited bonuses. The FFS group physicians, if full partners, were paid a percentage of net group revenues, adjusted for individual productivity (defined in terms of the production of revenue generating services); if new to the group, physicians were salaried. In addition, the PPG physicians were somewhat younger (collectively) than the FFS group. The comparative youth of PPG physicians and their more recent affiliation with the hospital may have hampered establishing colleague relationships within the hospital medical staff.

"Social" and "economic exchanges" were used to characterize the informal relationships among physicians. Social exchanges involve explicit expectations of reciprocity grounded in mutual trust, the rewards of which tend to be social (e.g., conferring respect by requesting expert advice—a consultation). Social exchange is usually diffuse, imprecise, and highly personal. Economic exchange is typified by explicit understandings and impersonal expectations concerning economic rewards (e.g., payment of a fee).

Earlier studies by other researchers emphasized the business aspects of physician interrelationships by trying to determine on whom a physician depends for patient referral—clients or colleagues. The researchers also commented on other authors' studies which emphasized the social aspects of physician exchange, suggesting that enhancement of status serves as a reward in some exchanges, and status expectations condition a physician's perception of other rewards and costs inherent in an exchange relationship. The authors believe interphysician exchange combines both economic and social exchange concepts. They refer to this as "colleague exchange."

Study Expectations: Because of group constraints, and because exchange within a group benefits a group, the authors expected to find the fee-for-service group practice building their colleague network inward. An increase in consultations within the group would obviously generate a higher level of group income.

It was also theorized that affiliation with prepaid group practice, given its cost control possibilities (the absence of incentive to promote unnecessary utilization of physician services), minimizes the economic rewards inherent in informal physician exchange. A high frequency of colleague exchange (inside or outside the group) was not expected from PPG physicians because neither their practice nor their net revenue is directly dependent upon colleague exchange.

Also, because of the non-traditional aspects of group practice, particularly prepaid, reciprocal exchange of consultation requests was not expected between group practice physicians and other physician colleagues. Reciprocity for prepaid group physicians was not expected to be high because of their lack of incentive to engage in network building.

The researchers expected that affiliation with group practice would tend to shift colleague exchange relationships away from the social to the economic. Thus, as medical practice becomes more formally organized, interphysician exchange relationships are expected to become more formal, based less on the implicit, personal understanding characteristic of traditional practice. An explanation of this shift may be that organized physician settings result in exchanges becoming organizational, and interpersonal, leading to greater formality in referral and consultation channels.

Based upon the differing organizational and reimbursement mechanisms, the authors also expected to find FFS physicians more frequently engaged in consultations (given the incentive of fee-for-service and informal group norms that emphasize group survival). The unaffiliated group of physicians studied was expected to exhibit an "average" pattern of consultation, having no particular incentive to use or not use consultations.

Organizing physicians into a group practice introduces the concept of focusing on group survival as well as on individual members. Also, members adopt the attributes of the group, with all its implications for status and stereotyping. For example, members of a prepaid group practice may be perceived as having lower status than other physicians, because of the nontraditional method of payment and their form of organization.

One question raised by the study was whether group practice physicians favor their own colleagues in choosing consulting partners, even when practicing within the hospital. It was generally expected that because of financial and organizational constraints, members of both groups would tend to choose partners from their own group, and both would use residents as consultants. Since resident consultants are a "cost free" choice and PPG physicians are formally restrained from developing exchange relationships with other more permanent hospital medical staff members, PPG physicians were expected to choose resident consultants more frequently than other physicians do.

Because of different payment systems, the two practice groups were expected to vary in utilization of both technical and clinical services. Incentives incorporated into the PPG practice suggested those physicians would be disinclined to use unnecessarily technical services. No financial exchange results from the prepaid group's utilization of cinical services as long as such services are both requested and rendered by PPG members. Given the limited availability of member consultants for small PPG groups (like the one in this study), it appeared highly likely PPG physicians would have to seek consultations from non-group members. However, unless they consult with hospital residents, for which no fee is charged, charges for consultations outside the prepaid group would reduce net revenues and would discourage PPG physicians from requesting consultations. It was anticipated, then, that there would be fewer consultations requested by PPG physicians.

FFS physicians were expected to have no particular incentives to use or not use technical services, since, in their practices, such costs are passed directly to patients or third party payors. However, because consulting activity done within an FFS group generates income to be disbursed among the physicians in the group, there appeared to be an incentive for FFS physicians to use clinical services within their group. Thus, the authors expected the number of consultations, both requested and rendered, would be higher for the FFS physicians than the PPG or UA physicians. (Unaffiliated physicians were seen as having no particular financial incentive to use technical or clinical services within the hospital.)

Findings: PPG physicians exhibited a tendency to go outside their group to select consulting partners, choosing outsiders more often than FFS physicians did. They also chose resident consultants more often than FFS physicians did. The findings also reflected a distinct preference for colleagues of one's own practice group, especially by FFS physicians. UA physicians did not exhibit any great preference for colleagues from either group practice as consultants.

The findings seemed to indicate that all three groups of physicians chose outside partners less often than expected. PPG and FFS physicians preferred unaffiliated "outsider" consultants over those in the other group practice. This is interpreted as evidence of the competitive posture of the two groups. Also, PPG physicians requested more than three times as many consultations from outsiders than they themselves were asked to render to outsiders. This contrasts with the almost equal reciprocal pattern observed for FFS group physicians. As expected, PPG physicians requested and rendered fewer consultations than the FFS group.

Examining the equality of exchange between physicians in the various groups, the authors learned that PPG physicians experienced more unequal, or, less reciprocal exchanges than the FFS group physicians. The UA physicians exhibited a slight preference for FFS group physicians as consultants over those in the PPG group.

The study also revealed that: physicians in prepaid groups were more able to limit admission rates than length of stay or surgical procedures; patients in the PPG group utilized relatively lower levels of both technical and clinical services when compared with patients in other payment plans such as Blue Cross, Medicare, Medicaid, etc.; and, prepaid group physicians engaged in less consulting but used non-group consultants to a greater degree, relied more heavily on medical residents as consultants, and had a lower degree of reciprocity in consulting exchange.

Conclusions: The studies' five main points were: (1) FFS group physicians requested and rendered more consultations than PPG physicians; (2) although all physician groups tended to choose consultation partners from within their own group, this was especially true for FFS group physicians; (3) although all physician groups chose residents as consulting partners, PPG physicians tended to do so to a greater degree than expected; (4) the physicians in the two group practices demonstrated a pattern of mutual avoidance in choosing consulting partners; (5) PPG physicians did not appear to have achieved reciprocity in the exchange of consultations.

Study results indicate that many structural aspects of group practice have the capacity to influence physician practice patterns within a hospital. Consistent with expectations, the analysis of technical services indicated group physicians, when compared to unaffiliated physicians, utilize a lower level of technical resources, with PPG physicians experiencing the lowest level of utilization. A significant difference between the groups was noted as regards levels of utilization of clinical resources.

The significantly different patterns of consultation observed between the PPG and FFS practices are important because of what they imply about the effect of group structures. The limited, but expected, impact of the physician groups on use of technical services is consistent with findings that group affiliation affects within hospital use of services less than admission patterns and that non-hospital based groups reduce subscriber costs of such care less than hospital based groups do.

Another implication is suggested by the significant effect of group affiliation on the use of clinical services. The greater number of consultations generated by FFS group physicians (relative to UA and PPG physicians) may reflect the importance of such referrals as sources of revenues in such practice arrangements. In an indepth examination of this data, the authors found that the physicians practicing within the study hospital consistently chose consultation partners from within their own groups. This was particularly true for FFS group physicians, as previously indicated. This indicates that fee-for-service group structure reinforces the incentives to generate and share in consultations, referrals, and other forms of clinical services.

On the other hand, the relatively fewer consultations for the PPG physicians may reflect more than the incentive effects of prepayment. (This group had the lowest request/render ratios for consulting outside of their group, compared to the FFS and UA physicians.) This may have been because the prepaid group was not fully integrated into the informal hospital physician structures, the authors indicate.

The different levels of consultation could also have cost and quality implications. Low consultation activity could reflect poorer quality care through underutilization. However, high rates of consultation could reflect excessive and unnecessary use stimulated by the incentive effects of fee-for-service payment. These possibilities were not examined in this study.

The authors warn of drawing generalizations from their findings because of limitations in study methods and data, especially since the data were obtained from only two group practices (in the same hospital), and were for a relatively short sample period. They recommend further testing to determine the effects of group practice on the informal practice patterns of physicians, but believe there is preliminary indication that the structure of informal physician relationships may be significantly altered once physicians are subjected to organizational constraints.

Although a formal report was never published, the authors, Roice D. Luke, Ph.D., and Michael A. Thomson, M.S., wrote two articles about the study: "Utilization of Within-Hospital Services: A Study of the Effects of Two Forms of Group Practice," *Group Practice Journal*, September 1980, pages 13-30, and "Group Practice Affiliation and Interphysician Consulting Patterns Within a Community General Hospital," *Journal of Health and Social Behavior,* Volume 21, December 1980, pages 334-344.

Swing-Bed Experiments

This report, "An Evaluation of Swing-Bed Experiments to Provide Long Term Care in Rural Hospitals," was written by the University of Colorado Health Sciences Center under contract to the Health Care Financing Administration (HCFA). The report describes and evaluates three swing-bed experiments conducted by a State hospital association and several Blue Cross associations which were under contract to the Social Security Administration, one of HCFA's parent organizations prior to March 1977. The experiments were conducted between 1976 and 1981 in 82 rural hospitals in Texas, Iowa, and South Dakota. The hospitals, ranging in size from 15 to 94 beds, were in areas where long term care facilities were inaccessible and/or inadequate. Hospitals were thus permitted to provide long term care in beds usually restricted to providing acute care.[1]

Small rural hospitals usually lack the financial advantages which can accrue from economies of scale and shared service arrangements more common in metropolitan areas. This often leads to financial instability and possible closure for many rural area hospitals. In contrast, Medicare and Medicaid certified rural nursing homes often have high occupancy rates and patient waiting lists.

The swing-bed concept was proposed as a possible solution to the dilemma of rural communities' excess hospital beds and scarcity of certified nursing home beds. Swing-bed refers to a hospital bed which can be used to provide care to either acute or long term care patients. This enables an acute care hospital to provide care to patients who would ordinarily receive care in a nursing home.

Prior to the swing-bed experiments, the University of Colorado researchers hypothesized that Medicare beneficiaries receiving hospital care in areas with a shortage of certified skilled nursing facility (SNF) beds were probably being kept at the acute care level longer than necessary. The researchers also theorized that if more long term care beds were available in project hospitals, patients would probably be more promptly reclassified to a more appropriate level of nursing care, leading to a decrease in acute care utilization.

All three swing-bed experiments were based on several basic assumptions. First, providing long term care in existing rural hospitals is more cost effective than other alternatives, such as building new nursing homes. Second, advantages accrue to long term care patients and their families and friends from the convenience of visiting patients in their own communities. And, third, benefits accrue to rural areas which continue to maintain community hospitals (e.g., continued availability of acute and emergency care, a continued means of attracting needed health professionals, and the continued maintenance of these hospitals as vital parts of the economies of rural communities).

Medicare reimbursement for routine long term care (room and board, nursing and other services usually provided patients) in Medicare and Medicaid certified SNFs or hospital based distinct part facilities is based on the cost to the institution of providing that care. Under the experiments, participating hospitals' reimbursement consisted of a per diem payment for skilled nursing care plus an incentive payment to encourage hospital participation in the swing-bed experiment. Reimbursement for ancillary long term care services (diagnostic, laboratory, pharmacy, and other services given in accord with patients' needs) was handled in accordance with normal acute care Medicare reimbursement procedure.

Some of the Federal and State licensure health and safety requirements were waived for participating swing-bed hospitals. In addition, all three experimental States waived certificate of need requirements for the participating hospitals' long term care services.

The State hospital association and several Blue Cross associations conducted education and training programs which explained experiment goals, benefits, and procedures to participating hospital staff and the public. Hospital staff training emphasized financial matters, changes in Medicare Cost Reports, billing and claims procedures, and the skilled nursing services which would be reimbursed under the experiments. Public meetings emphasized the benefits of the experiments to both hospital staff and community residents.

The experimental swing-bed hospitals, all of which volunteered for the studies, were not typical of other rural hospitals in their respective States. They tended to be smaller, have lower utilization, and fewer staff (both professional and support staff). Additionally, they offered fewer SNF specialty services (e.g., rehabilitation, physical, occupational and speech therapy, and social services).

Findings: Evaluation data were obtained from several sources: telephone surveys of hospital administrators, directors of nursing, and chiefs of staff of the 82 project hospitals; printed survey questionnaires mailed to project hospital staff physicians and nursing home administrators of nursing homes in the three project States; the Medicare Cost Reports of the project hospitals; and, data from the American Hospital Association Survey concerning financial, utilization, and staff characteristics of hospitals.

The experiments identified an unmet demand for long term care in many rural communities. Although the country's total health care costs would increase slightly under a swing-bed program, the report indicates that the unit cost (cost per long term care patient day) in swing-bed hospitals is less than the cost associated with providing similar care in nursing homes. The report researchers consider the quality of care provided in the experimental hospitals adequate, even though the care was of a lower level than the care provided in a group of comparison nursing homes.[2] The researchers believe the discrepancy is not substantial. They expect it will disappear over time if quality assurance steps are applied and hospital staff become familiar with long term care patient problems.

Approximately 87 percent of the staff physicians and 73 percent of the chiefs of staff who responded to the survey questionnaires wanted the experiments continued in their hospitals. The report notes that staff physicians and chiefs of staff who favored the experiment were more likely to respond than those who were unfavorable.

About 60 percent of the nursing home administrators who responded to survey questionnaires felt that a national swing-bed program should be implemented. The two main benefits of the swing-bed approach cited by the hospital staffs and nursing home administrators surveyed were the satisfaction of meeting their areas' long term care needs when nursing home beds are unavailable, and the more efficient use of space and nursing staff.

Nursing home administrators' most frequent concern was whether hospital staffing was adequate to provide both acute and long term care. They also expressed concern about the high costs of hospitals (in relation to nursing home costs), hospitals competing with nursing homes for long term care patients, and hospitals not representing a "home-like" environment.

Swing-bed admissions tended to take place in counties where nursing homes had higher occupancy rates, suggesting that swing-bed admissions did not occur in lieu of nursing home admissions. These findings led the University of Colorado researchers to conclude that the availability of hospital swing-beds does not affect rural nursing home occupancy rates.

Based on report estimates of nationwide utilization, projections (in 1978 dollars) of the cost of a nationwide swing-bed program in rural areas ranged from $14.2 to $37.0 million for all payors. Cost to the Medicare program was estimated at between $5.2 and $13.5 million. Medicaid, a few other third party payors, and private payors (primarily patients and their families) paid the balance of the long term care swing-bed costs. (These estimates did not take into account any possible reductions in acute care expenditures.) The impact of such additional costs on total national hospital care expenditures is minimal, less than a one percent increase.

Expected Implementation Problems: Rural hospitals' accounting and financial capabilities are not as sophisticated as those of larger metropolitan hospitals. Hospital medical, nursing, and administrative staff will have some difficulties adjusting to the different health care needs and service requirements of long term care patients. Initially, there will be resistance to change because of a natural aversion to "Federal intervention," some people's attitude that an acute care hospital "should not become a nursing home," and a general concern in some communities about changing the role of acute care hospitals.

Report Recommendations: The report recommends that rural hospitals throughout the country should be allowed to provide swing-bed care on a voluntary basis. The report also recommends that the swing-bed program only apply to existing acute care beds in rural hospitals with distinct part long term care units or with long term care beds, when nursing home beds are unavailable.

Since acute care hospitals are capable of providing adequate long term care, but are less likely to provide certain nonmedical services (e.g., social-recreational, therapeutic-mental health, and occupational therapy services) as adequately as many nursing homes, the report recommends that hospital based long term care provided in swing-beds should be subject to standard PSRO review procedures[3] and Medicaid long term care review programs. Also recommended is that swing-bed hospitals be required to meet some of the Medicare/Medicaid SNF health and safety requirements (e.g., staff development, social services, patient activities, and discharge planning standards).

Because orientation information is critical to the success of a national swing-bed program, the report researchers contend that written guidelines for physicians and nurses regarding the provision of long term care and the differences between long term and acute care should be disseminated to all eligible hospitals. They also believe that a swing-bed program cannot succeed unless administrative guidelines regarding reimbursement policy and forms completion are disseminated to hospital administrators.

Initially, the researchers believe, eligibility in this program (if it is nationalized) should be restricted to rural hospitals which satisfy State level certificate of need requirements for long term care beds. In addition, future experimentation and research should be designed to assess the appropriateness of swing-bed care in metropolitan areas.

Conclusions: First, a national swing-bed program should be implemented in rural areas. Second, such a program would benefit rural communities' long term and acute care needs. Third, several financing, quality assurance, and regulatory issues must be considered in developing a national swing-bed program. Fourth, swing-bed hospitals participating in a national program will probably admit long term care patients with greater rehabilitation potential and shorter term needs than the typical nursing home patient. Fifth, there would be very little increase in institutional long term care utilization if the swing-bed program was implemented in rural areas across the country.

Further information concerning the swing-bed experiments can be obtained by contacting Spike Duzor, HCFA, Office of Research, Demonstrations, and Statistics, Office of Demonstrations and Evaluations, Evaluative Studies Staff, Room 1-E-6, Oak Meadows Building, 6325 Security Boulevard, Baltimore, Maryland 21207, Telephone (301) 597-2367, FTS 987-2367.

Copies of this report, An Evaluation of Swing-Bed Experiments to Provide Long Term Care in Rural Hospitals: Volume II: Final Technical Report, *(HCFA Publication No. 03083) may be obtained from the Health Care Financing Administration, ORDS Publications, Room 1E9, Oak Meadows Building, 6325 Security Boulevard, Baltimore, MD 21207.*

NOTES:

[1] Under Medicare and Medicaid, a physically distinct part (such as a building or wing) of a hospital can be certified as a long term facility, separate and apart from the hospital's acute care certification. Additionally, Medicare policy and some Medicaid State Plan policies in effect at the time this report was written, allow a hospital to provide long term care at acute care rates if it can be documented that there is no nursing home bed available for the patient. These Medicare and Medicaid policies are affected by Section 902 of the Omnibus Reconciliation Act of December 1980.

[2] The report notes that the care provided in the certified SNFs used in the study was probably above average.

[3] The report was written before a decision to eliminate PSRO funding was finalized.

Ambulatory Care Minimum Data Set

This 1980 report on the Uniform Ambulatory Medical Care Minimum Data Set (UAMCMDS) was prepared by a Technical Consultant Panel (TCP) selected by the Public Health Service's National Committee on Vital and Health Statistics (NCVHS). It is the first review and update of a UAMCMDS originally developed in 1974 to meet the ambulatory care data needs of government agencies and private sector organizations which collect, analyze, or disseminate information related to the provision of ambulatory care. Panel members were selected from many relevant disciplines (e.g., health professionals, systems specialists, researchers, and hospital administrators), though none from the NCVHS, so that the technological aspects and the applicability of the UAMCMDS to a broad array of users could be reviewed.

Due to rapidly escalating health care costs and the changing environment of ambulatory care, there has been increased interest in ambulatory health care as a possible lower cost alternative to institutional health services. Moreover, the promise of more accurate information and economical data collection, the NCVHS hopes, will lead to more cost effective information systems, reduced data systems costs, and will help minimize the reporting burden of respondents.

In the 1980 TCP revision, the ambulatory care minimum data set consists of 18 basic patient, provider, and encounter data items:

Patient Data Items

Personal Identification
Residence
Date of Birth
Sex
Race and Ethnic Background

Provider Data Items

Provider Identification
Location or Address
Type of Practice
Profession

Encounter Data Items

Date and Place of Encounter
Patient's Reason for Encounter
Diagnostic Services
Problem, (Provider's) Diagnosis, or Assessment
Therapeutic Services
Preventive Services
Disposition
Expected Principal Source of Payment
Total Charges

The consultants stress that the most important purpose of this data set is to assist in the provision of quality patient care. Therefore, they concentrated on those components of medical records that, minimally, must be present to ensure quality care as well as issues related to the system in which the information will be recorded.

Definitions: The report includes definitions and explanations of the 18 data items in order to clarify the kinds of data that should be recorded under the UAMCMDS. An ambulatory care encounter is defined as one in which the patient is neither hospitalized nor institutionalized at the time of the encounter. An encounter is defined as a face-to-face contact between a patient and a provider. The provider is defined as a health professional who exercises independent judgment at some time during the care of the patient. Under this definition, a health professional carrying out a test or rendering a service ordered by another health professional is not the provider; the prescribing professional is the provider.

Settings in which ambulatory care can occur are a physician's office, an outpatient clinic (whether or not affiliated with an inpatient facility), a health center, and a patient's home. By definition, the UAMCMDS does not include any encounters between a provider and an inpatient that occur at a nursing home, general hospital, or psychiatric hospital, even when the provider ordinarily provides services in an ambulatory care setting.

The panel stresses that the "Personal Identification" and "Provider Identification" items should include a unique identification number for control purposes, and which can be carried over to any future national health insurance system. The "Residence" and "Location or Address" should be the patient's and provider's "usual" home or place of practice but may also contain a temporary address. If there is more than one provider during an encounter, the one with primary responsibility is the one identified.

Patient characteristics, the TCP indicates, should be obtained at the time of enrollment or registration. Provider information should be recorded when a provider begins work in a particular setting and updated as needed. Encounter data items should be obtained at the time of each ambulatory care encounter between a provider and a patient. Charges and payment data should be recorded as part of the billing process at the time that the fees associated with the specific encounter are determined. The consultants emphasize that charges are not identical with costs. Also, the determination of actual costs of ambulatory services requires cost allocation audits and analyses, which are beyond the scope of the minimum data set.

The "Encounter Data" items help compare patients' reasons for seeking an encounter with providers' assessments of patients' health problems. Such information, when collected and analyzed, should improve patients' input into their own health care, help providers better understand the relationship between patients' perceived needs and providers' decisions concerning such needs, and could be used to determine health care needs more precisely.

The data set is patient oriented, rather than provider oriented. The panel, therefore, modified the structure of the 1974 data set to reflect all the services provided for a patient during the course of an ambulatory encounter, rather than the services rendered by one provider. The 1974 data set definition of encounter was also modified to clarify the role of the provider and to reflect a greater portion of services provided by non-physicians (e.g., nurse practitioners, psychiatric social workers, etc.).

The consultants tried to limit the minimum data set to those items necessary to health care delivery which can be routinely recorded for each encounter in an ambulatory health care setting, and which benefit both the patient and the provider, (e.g., information needed to: aid the provider in recall of treatments, diagnoses, etc.; facilitate response to inquiries presented by data users; make available information required for reporting for reimbursement purposes; and, document encounters and protect against malpractice claims). Data that would have universal application in Federal, State, and other third party funded programs could also be abstracted from these records. Additionally, the consultants also believe that a carefully limited data set will be more widely recorded, more likely to be defined uniformly, more easily retrievable, and, therefore, more valuable for planning and other purposes not involving direct patient care.

This report emphasizes three main concerns.

- The 18 data items constitute the "minimum" amount of data which should be recorded for ambulatory health care encounters. The data set is designed to meet the common data needs of multiple user groups, not to meet the total data needs of any one user group. Specific needs of various users can be met by expanding the level of detail within an item or adding additional data items.
- The panel recommends that this minimum data set be entered into all ambulatory medical health care records in at least the detail specified in their report. Although desirable, all items need not be recorded in the patient's health record, some may be included in registration or billing records. In such cases, the capability should exist to link data from the various record sources. Also, some data items need only be recorded once and updated when necessary.
- Neither a survey or other data collection system nor a data collection "form" is recommended by the TCP. Data systems and forms will vary according to data needs of individual programs. When minimum data set items are included in a data system, the panel recommends that their definitions and minimal classifications be followed.

Recommendations: The report concludes with the panel's recommendations. The panel considered both public and private sector needs. However, they realized that some of their recommendations may not be totally applicable to one or the other sector and may require adaptation to assure specific applicability.

In addition to specifying the content of the minimum data set and that it should be entered into all ambulatory health care records, the consultants noted that there is no single classification scheme specifically designed for ambulatory health care. They believe that the NCVHS should encourage efforts to develop a comprehensive scheme to classify all the problems presented by an ambulatory care patient population. Such a classification scheme, it is felt, should accommodate the layperson's terms for diseases and symptoms, psychosocial and behavioral problems, and problems of living and working, as well as the pathological descriptions of morbidity as currently classified by the International Classification of Diseases (ICD), the current basis for all morbidity reporting.

Since the panel wants the minimum data set to produce quality data, they also recommend that the NCVHS consider the need to: (1) establish guidelines for recording data; (2) monitor the quality of the data reported by users of the UAMCMDS; and, (3) support research to assess the extent of use of the data set over time, examining user characteristics, the degree of adoption or adaptation of the items, their definitions, the data set structure, and the quality of data retrieved.

The consultants strongly support maintaining the confidentiality of patient related information in health care records. The "need to know," they state, should be a primary consideration controlling decisions about data to be recorded and reported. The TCP notes that the subject of confidentiality extends beyond the ambulatory medical care sector and overlaps with other health care system components. They, therefore, recommend that the NCVHS develop comprehensive recommendations for the maintenance of the confidentiality of medical care records information, including ambulatory health care records. Additionally, the NCVHS should also address the confidentiality of data collected and reported for statistical and research purposes.

Finally, the panel recommends that HHS and other Federal agencies that fund ambulatory health care programs accept the UAMCMDS. Further, HHS should designate an office to assume responsibility for promulgation of the data set and its adoption, including its definitions, by those Federal programs requiring the reporting of ambulatory care events. This would encourage uniformity in Federal reporting for the minimum data set items. The panel also reiterated a previous NCVHS recommendation that private health care institutions, professional organizations, and insurance carriers endorse and agree to use the data set.

The panel concludes that the routine and uniform recording of the revised minimum data set information will greatly enhance the value of health records to the patient care process and will increase the potential of health records as an information source. They also contend that this report will help many government agencies and private sector organizations with their ambulatory care data needs.

Copies of this report, Uniform Ambulatory Medical Care: Minimum Data Set, *(DHHS Publication No. PHS 81-1161) may be obtained from the Public Health Service, Office of Health Research, Statistics, and Technology, National Center for Health Statistics, Hyattsville, MD 20782.*

Medicaid Nursing Home Reimbursement Series

This three volume series prepared by The Urban Institute, a nonprofit policy research and educational organization, identities and assesses the various incentives to Medicaid reimbursement systems in New York, Minnesota, and Illinois. The Urban Institute discusses the association of each State's reimbursement policy to cost containment, quality of care, access for Medicaid patients, and control of real estate manipulation. Under contract to the Health Care Financing Administration, the Urban Institute has attempted to analyze the way reimbursement policy has been made and applied at the State level.

The Urban Institute conducted several studies of the nursing home industry and other components of the long term care system. They examined the politics and economics of nursing home reimbursement in the State Medicaid programs of California, Colorado, Connecticut, Illinois, Louisiana, Minnesota, and New York. Reports, memorandums, testimonies, position papers, and other data concerning the development of States' reimbursement systems were collected. The Urban Institute also interviewed approximately fifteen persons from each State in order to complete their detailed review of political concerns, technical problems, design, and implementation of reimbursement systems.

The Urban Institute selected New York, Minnesota, and Illinois for this report since each State has tested several types of reimbursement approaches and has displayed a high level of complexity and inventivenes. In addition, these States can act as models for other States.

New York's Reimbursement System: In 1977, New York spent $1.28 billion on nursing homes, more than the total Medicaid budgets for any State except California. New York's Medicaid program spent over $867 million of its total $2.55 billion Medicaid budget on nursing home care. In this volume, the authors examine and analyze those changes in reimbursement policy that affected New York's Medicaid program during the period 1974-77. Specifically, they describe the scandals and allegations in 1974; the investigations that took place in 1975 which increased reimbursement regulations and revised capital reimbursement; the 1976 fiscal crisis, rate freeze, fair rental value, quality ratings, and boycott; the 1976 Moreland Act Commission reports, legislative compromises, legal battles, union troubles, and boycott; and, the 1977 joint executive-legislative task force.

The Urban Institute found several problems with New York's 1974 system. These inadequacies in the reimbursement system could have caused widescale default on property taxes, abandonment in poor communities, deterioration in the quality of care, and a rapid decline in the number of homes and beds. The author believe that the Department of Health was not staffed to do an adequate job."

In September 1974, New York State auditors found over $4.6 million in unwarranted Medicaid claims by 58 nursing homes audited during 1969-1970. The audit cost $168,000; almost 25 times that amount was found in available recoveries. The following year, Governor Carey convened the Moreland Commission to investigate the nursing home industry because of the 1974 audit finding. In 1975, there were 17 different government agencies from Federal, State, and local levels investigating the industry. According to the reports from these agencies, patient care was frequently poor and abusive, and there was widespread fraud in the industry. Because of the scandals, New York adopted a new method for capital reimbursement in March 1975 which is fully described in this paper.

The Urban Institute defines 1976 as the year of "confrontation, confusion and adjustment in New York. It was a year of reports and report responses, mostly it was a year of fiscal distress when the State and the industry had to learn to live with less." Faced with a $900 million deficit, Governor Carey proposed a budget that would "finance little that is new and discontinue most that is old." This Medicaid Fiscal Budget Bill was passed in 1976. The Hospital Association of New York State (representing approximately 100 nonprofit facilities) felt that the 1976 Fiscal Budget Bill's new method of reimbursement had major weaknesses.

"By 1977, the scandals had well passed the point of outrage and public disbelief. Reforms had been implemented and the effects of those reforms had become evident. It was a period when the State recognized that it may have been too zealous in its attempt to overhaul the industry and modified some of its more stringent policies."

Some of the authors' observations of New York's reimbursement system are: the 1974 system permitted nursing homes to incur excessive and overstated costs, and the scandals had more media coverage than the 1976 fiscal crisis. The fiscal crisis, however, had a much greater impact on the reimbursement rates and methodology. It forced the State to live with less and to structure its reimbursement system to accommodate this condition of scarcity.

"Whatever the outcomes, whatever the adjustments, we can be sure that New York will continue to change and that actions taken within the State will continue to affect the behavior of other States and the Federal government. The nature of the State's enormous Medicaid program, the State's increasingly binding fiscal constraints, and the intensity and complexity of the State's political environment insure instability, volatility, and experimentation in New York's Medicaid program. New York's actions will continue to be a part of policy discussions and considerations throughout the country."

Minnesota's Reimbursement System: Minnesota allocates more than 60 percent of its Medicaid expenditures to nursing home care. In fiscal year 1976, payments to skilled nursing facilities (SNFs) amounted to nearly $67 million and intermediate care facilities (ICFs) received approximately $118 million. Fifty-seven point six percent of the 1976 Medicaid budget of $322 million went for Medicaid payments to nursing homes.

This report evaluates Minnesota's 1977 reimbursement system. It discusses its development from Rule 49 in 1972, the implementation and modification of Rule 49 during 1973-74, the 1975 River Villa scandal, the Milton Committee in 1975-76, and the effect of legislation on reimbursement in 1976. It centers on the reimbursement for capital costs since this is the State's main concern and has been through several modifications and innovations.

Prior to 1972, when Medicaid was a State supported, county administered program, two reimbursement methodologies were used: a point system in which the level of reimbursement depended on the patient's care needs; and, negotiated rates, which were related to incurred costs. A cost-related system had been implemented in the late 1960's to control unnecessary funds spent on nursing home care. The State reviewed these cost-related rates using informal guidelines. These were called the RAU guidelines and functioned as the State's reimbursement methodology. (Robert Rau monitored nursing home payments in Minnesota's Medicaid agency.)

In 1971, the Minnesota Department of Public Welfare (DPW) froze both SNF rates and ICF rates for private, free-standing homes because of the "possible shortage of legislative funding for programs related to nursing homes." The rates did not affect State owned and hospital attached ICFs. In response to the freeze, many SNFs wanted to be reclassified as ICFs to escape the freeze effects. The Minnesota Association of Health Care Facilities (MAHCF), the State's largest nursing home association, challenged the legality of the freeze, and the State's use of the RAU guidelines.

In 1972, the State decided to reimburse each facility according to its historic allowable costs, thus developing Rule 49. Under Rule 49, DPW would set rates that served as maximums and the State would be allowed to impose a pro rata reduction in rates if appropriations were insufficient. The authors discuss other factors of Rule 49, in addition to its two primary goals and eight objectives. Between 1973-74, the new nursing home reimbursement system, Rule 49, was incorporated into the Medicaid program.

The "tagging law" is the most significant change in Minnesota nursing home policy during 1973. With this bill, the Department of Health (DH) was able to monitor the quality of care in nursing homes and could "tag" or fine a home that did not correct deficiencies found during a State inspection. The 1975 River Villa scandal was a direct result of problems with the administration of the tagging program.

The River Villa scandal began in February 1975 when the *Minneapolis Star* charged an owner of River Villa Convalescent Medicenter with being on the State Board of Health, therefore receiving "favored treatment" by DH. The *Star* also accused DH of licensing all of River Villa's beds as nursing home beds even though half the beds were used for detoxification by the county and were not inspected as nursing home beds, allowing River Villa to invest several thousand dollars into a $4.5 million facility. Due to the *Star's* report, a grand jury investigated the allegations, and a special joint legislative Select Committee on Nursing Homes examined legislative remedies to the quality and reimbursement issues raised by the River Villa scandal. The grand jury investigations led to the indictment and conviction of five individuals, one from a high ranking position in the Department of Public Health. "Charges of legislative complicity, corruption in DH, and enormous waste of public funds resulted in a much stronger legislative involvement in the Medicaid nursing home reimbursement policy than the State had ever experienced."

The Milton Committee was formed to review the reimbursement system and tighten the loopholes which permitted the River Villa scandal to occur. The Committee conducted reimbursement studies on cost structure, owner equity and return on investment, cost of quality, and facility valuation. In the Committee's final report, they recommended legislation that would increase the State's investigative and prosecutorial powers, reduce the industry's ability to influence regulating agencies, and tighten reimbursement provisions. This legislation was passed in 1976, and produced four types of changes in the reimbursement system: (1) it gave the State the ability to request separate audit reports for individual homes owned by the same owner; (2) it helped to eliminate the practice of Medicaid supporting actions which affected the State's best interest (e.g., political contributions, salaries and expenses of lobbyists, association dues, DH fines, and unsuccessful legal costs); (3) it restricted nursing homes participating in Medicaid from charging private patients more than 110 percent of the Medicaid rate for similar services; and (4) it replaced the earnings allowance with an investment allowance. The authors detail the 1977 changes to the 1976 Milton Committee legislation.

In The Urban Institute's analysis of Rule 49, problems with payment mechanism were seen. Rule 49 objectives are to "promote efficiency and economy, and treat all providers of nursing home care on a uniform basis." The State attempted to meet the uniform treatment objective by paying each provider on the basis of cost experience and by allowing for the individual circumstances of providers through a number of exceptions and qualifications to various Rule 49 provisions. The Urban Institute identified individual incentives, and speculated on the effects of investment allowance, recapture provision, continuous ownership bonus, the interest limitations, the occupancy constraints, or other reimbursement devices. The net effect of Rule 49 appeared to have slowed down the rate of growth within the industry. "The political and economic paradox of Rule 49 then is that despite the inordinate specificity of reimbursement regulations and the multiplicity of incentives and disincentives, no one knows the net effect the reimbursement system had on the industry."

Illinois' Reimbursement System: In fiscal year 1976, State payments to nursing homes amounted to more than $208 million representing 27 percent of the total Medicaid budget of $771 million. This section of The Urban Institute's paper describes the development of the 1967 point count reimbursement system, the 1971 *Chicago Tribune* scandals, the 1974 kickback schemes, the 1976 boycott, and the development of a cost-related reimbursement system.

The 1967 point count reimbursement system consisted of a base rate (minimum payment), a shelter factor (additional payment made to homes meeting certain specifications), an add-on (additional payment to facilities for specific services), and a point based patient evaluation. The point evaluation is the caseworker's checklist rating of a patient's ability to perform daily living activities and his or her mental status and nursing needs. Each checklist item is assigned a point value that represents a given dollar amount. This type of payment groups costs into three categories: support costs (laundry, dietary, housekeeping, utilities, and administrative expenses), nursing costs, and capital costs.

The first major Medicaid nursing home scandal in Illinois was publicized in a seven part series in the March 1971 *Chicago Tribune* revealing instances of patient neglect and abuse, unsanitary physical conditions of homes, improper use of personnel, and ineffective enforcement of regulations. As a result of this scandal, Mayor Richard Daly ordered an immediate upgrading of nursing home requirements and an increase in facility inspections. The *Tribune* stated, "a majority of homes were operating in gross violation of standards and that this was the result of inadequate staff, incompetent, and/or corrupt public agencies." The Department of Public Health (DPH) admitted that more than 50 percent of the nursing homes failed to meet minimum standards. By February 1972, 62 homes voluntarily closed because they were unable to comply with standards, 13 voluntarily changed to a lower level of care, 5 had their licenses revoked, and 31 had DPH payments withheld until they were able to comply with the regulations.

In 1974, massive kickback schemes were discovered between a small number of nursing home operators and pharmacists. As a result, a task force was created to examine problems in the Medicaid reimbursement program. The task force identified these problems as: increases in reimbursement with the number of points assigned to a patient, therefore, nursing homes exaggerated the severity of the patient's condition; facilities accepted patients with point counts above a certain level; the point system discouraged nursing homes from helping patients become self-reliant; and, the point system provided a disincentive for quality care because homes received more profit by lessening costs and lowering quality of care.

The Department of Health, Education and Welfare (now the Department of Health and Human Services) required ICFs to meet Life Safety Code Provisions in 1975. These provisions were costly to homes caring for their upgraded patients. The upgrading also increased the number of ICF patients thereby making any increases in the base rates more expensive. Due to these provisions, the State froze rates in 1976, causing the executive director of the Illinois Association of Health Care Facilities to build a coalition of 400 homes from within his association and the remaining five nursing homes. The coalition's purpose was to force the State to meet their demands. The homes then refused to admit Medicaid patients until rates were raised.The boycott ended five weeks later because of the threat of antitrust action, and Governor Thompson's commitment to listen to the industry and action to "clean up the Medicaid mess."

In 1978, Illinois received approval for a cost-related system that retained the point system but included a method for establishing the dollar value of a point and applied it only to nursing costs. The remaining operating costs were reimbursed up to the cost experience of 50 percent of skilled care and intermediate care facilities within a given geographic area. Capital costs were determined by disaggregating homes by age and location, and reimbursing according to the group experience within each cell.

In conclusion, the authors mention that the point system was the most distinguishing and controversial characteristic of the Illinois reimbursement system. This system allows the State to link patient disability condition to reimbursement, and the system attempts to overcome incentives to search for the healthiest patients.

"Illinois has constructed a flexible and innovative approach to nursing home reimbursement." It permits continual monitoring and adjustment to the reimbursement system relationship to individual patients, the total patient population, individual homes, and to the industry as a whole.

Copies of The Urban Institute's report, "Medicaid Nursing Home Reimbursement Series," *are available from The Urban Institute Press, 2100 M Street, NW, Washington, DC 20037. Volume 1—New York, costs $7.00, Volume 2—Minnesota, and Volume 3—Illinois, cost $6.00 each. All three can be purchased for $15.00.*

annotated bibliography

***Medicare Is—But Is Not, A Physician's Guide,* HHS, HCFA Atlanta Regional Office, 101 Marietta Tower, Atlanta, Georgia 30323.**

This short, attractive booklet is the first of three produced by HCFA's Atlanta Regional Office to introduce new physicians to HCFA administered programs. To provide doctors with a general understanding of the Medicare program, the booklet includes a brief history of the program and explanations of how the program is funded and administered.

Several pages discuss Medicare's assignment method, with physicians having the choice of either directly billing a Medicare patient or billing Medicare for their services. It is pointed out that physicians accepting assignment (billing Medicare) are agreeing to accept Medicare's payment as payment in full for their services. Another section contains instructions concerning the completion and submission of the Medicare claim form and itemized bills under both the assignment and direct patient billing methods. Of special interest to physicians is the fact that incomplete or erroneously completed forms or bills cause nonpayment or processing delays, and physicians are encouraged to contact Medicare carriers regarding any Medicare claims service problem.

The booklet utilizes examples to demonstrate physician and patient rights, responsibilities, and benefits under both billing methods. Also of interest to physicians is information about the types of health expenses covered and not covered by Medicare, and a list of the Southeastern insurance carriers that administer Medicare's supplementary medical insurance program in that area.

"The National Nursing Home Survey: 1977 Summary for the United States," *Vital and Health Statistics,* Public Health Service, National Center for Health Statistics, Series 13, No. 43, HEW Publication No. PHS 79-1794, Reprinted June 1980.

This report is based on a nationwide sample survey conducted May through December 1977 in all types of nursing homes (whether or not they participated in the Medicare or Medicaid programs) in the conterminous United States. It presents 43 tables without summarization, interpretation, or conclusions. The data presented measure nursing home utilization and describe, among other things, facility and staff characteristics, staffing patterns, cost of providing care, health and functional characteristics of residents, and discharge characteristics.

Some of the findings cited: arteriosclerosis and heart trouble were the most common chronic patient conditions, almost double the incidence of mental disorders and senility; 92 percent of the patients were white, 71 percent female, 62 percent widowed; approximately one third of the patients were discharged in under one month, three quarters stayed less than one year, about 70 percent of those discharged either transferred to another health facility or died, and about three quarters were discharged alive.

"Nursing Home Utilization in California, Illinois, Massachusetts, New York, and Texas: 1977 National Nursing Home Survey," *Vital and Health Statistics,* Public Health Service, National Center for Health Statistics, Series 13, No. 48, DHHS Publication No. PHS 81-1799.

This report presents selected characteristics of U.S. nursing homes and of homes in five States. California, Illinois, Massachusetts, New York and Texas were identified on the National Master Facility Inventory (NMFI) as having the largest proportion of nursing home residents. Nursing homes included were classified by the NMFI as nursing, personal, and domiciliary care homes, as well as all nursing homes that opened for business since the first NMFI was conducted.

The 1977 National Nursing Home Survey conducted by the National Center for Health Statistics from May through December 1977, covers facility characteristics (bed size, ownership, certification, staff), and measures of utilization (financing of resident days of care, primary source of payment, occupancy rate, discharge status—alive or dead, costs of providing care, charges for care). "Estimates of the number of facilities, beds, residents, full-time equivalent employees, and the average monthly charge are based on 1977 data; and estimates of the annual occupancy rate, resident days, discharges, and cost per resident day of care are based on 1976 data."

The survey findings indicate that:

"From May through December 1977, there were about 6,700 nursing homes in the 5 States representing about 35 percent of the 18,900 nursing homes nationwide."

California had 16 percent of the nursing homes nationally and 9 percent of the beds, compared to New York with only 5 percent of the homes and 8 percent of the beds, reflecting a dramatic difference in average bed size.

In 1976, about 60 percent of the nation's resident days of care in nursing homes were financed by the Medicaid program. In 1977, about 48 percent of the nation's nursing home residents reported Medicaid as their primary source of payment.

Approximately 1,117,500 persons were discharged from the nation's 18,900 nursing homes in 1976, 74 percent were discharged alive. Significantly higher percentages of live discharges were found in California (82 percent) and Texas (83 percent).

In 1976, the national average cost to a nursing home for a single resident day of care was $23.84. The costs per resident day in California ($21.56), Illinois ($21.11), Massachusetts ($24.23), and Texas ($19.33) were similar to the national figure. However, New York's cost per resident day of care ($40.12) was about 68 percent higher than the national average.

In 1977, the elderly population (65 or older) represented about 11 percent of the total U.S. population, with about 5 percent residing in nursing homes. The average nursing home resident in the 5 States and nationally was white, female, widowed, and about eighty years old.

About 86 percent of the nation's nursing home residents require assistance in bathing; 69 percent require assistance in dressing; 53 percent need help to use the toilet; 33 percent require assistance in eating; 66 percent were chairfast, bedfast, or walked only with assistance; and, 45 percent had difficulty with bowel and/or bladder control. About 23 percent of the nation's nursing home residents were dependent in all 6 of these activities.

Blendon, Robert J., Sc.D., "The Prospects for State and Local Governments Playing a Broader Role in Health Care in the 1980s," ***American Journal of Public Health,*** **Vol. 71, January 1981, pages 9-14.**

The author, Senior Vice President of the Robert Wood Johnson Foundation, discusses State and local government roles in the health care of the future. He speculates on increased direct provision of personal health services by municipal hospitals, and by State and local government health departments. Presented are examples of major changes in government responsibilities in the past and changes expected for the future, based on the author's analysis. Dr. Blendon believes major changes in government responsibilities are associated with: public concern about a national problem; public attitudes about the status of health care, in addition to public disagreement concerning the role government plays in the delivery of care; and, most importantly, the rationale for public authorities directly providing health care. "This rationale is gradually eroding and with it the political constituency for public health care institutions. Without a broader, more recognized mission, current levels of public health care responsibilities and expenditures will be difficult," the author states.

Dr. Blendon's agenda for the 1980s includes hope for a public concensus to emerge, supporting the expansion of local government responsibilities to include the health care needs of those suffering from "medicalized" social problems (drugs, alcohol, violence, child abuse, etc.), and those living in environments unable to sustain private arrangements for providing health care due to barriers of geography, language, culture, crime, etc. If the public agrees with these additional responsibilities, the 1980s will witness a substantial expansion of patient care responsibilities and financial support to today's municipal hospitals and public health departments; however, if public support is not enlarged, many local public health care responsibilities and expenditures will be reduced, Dr. Blendon asserts.

"The degree of public satisfaction with health care is such that the public will not be receptive in the 1980s to proposals which constitute a sharp break with America's established health care practices. Put simply, the public does not currently envision a very different set of future responsibilities for governmental institutions."

Clarke, Gary J., "The Role of the States in the Delivery of Health Services," ***American Journal of Public Health,*** **Vol. 72, January 1981, Supplement, pages 59-69.**

This article discusses the role, performance, and future of States in the health care system. The author, who is Deputy Assistant Secretary for Health Planning and Development, Florida Department of Health and Rehabilitative Services, finds that States have made tremendous strides in administering health programs, regulating health costs, and providing health benefits. Concluding there is no clear evidence that the Federal government is necessarily a more beneficient provider or a tougher enforcer, and recognizing there are no easy answers or conclusive solutions, he notes that "Federal programs may guarantee only a uniformity of sorts, not necessarily better, more responsive, or more innovative government programs."

The author indicates that spending too little for health purposes is the most frequent criticism leveled at States. Although total health expenditures by the Federal government are more than twice as large as combined State and local expenditures (1978: 68.2 percent, Federal; 31.8 percent, State/local), the article shows that Federal and State health care budget allocations are comparable (Federal, excluding Defense and Veterans Affairs—13.4 percent; States—13.9 percent).

Using information from a Feder and Holahan analysis of Medicaid published by The Urban Institute ("National Health Insurance: Conflicting Goals and Policy Choices"), the article states that "most State Medicaid programs are pursuing national objectives, several States are taking innovative approaches to control costs, and administrative problems reflect Medicaid's complexity more than State ineptitude." It also concludes that most innovations and improvements in administering the Medicaid program have come from States rather than Federal direction, and that Federal administration, with requests for uniformity, serves little national purpose and may actually discourage responsiveness to local needs, creativity, and growth of knowledge. A classic study of State-Federal relations identified by the author is represented by States developing a program, the Federal government selecting the idea and requiring all States to adopt it, and the Federal government then narrowing the scope of opportunity for significant State experimentation by subsequent rules, regulations, and statutes.

Long run, major changes in the health care system of the '80s are identified. These include: the States as important regulators of health care costs, with greater responsibility for planning and direction; a continued preeminence of State and local governments in the area of traditional public health concerns; and, a growing awareness of the Federal government's limits, with a sense of uncertainty that Federal public policy will necessarily be cost effective or produce its intended effects.

Finally, the author believes "each layer of government needs the other if promotion of the public good is to be achieved," and "a new generation of creative Federalism, serving both national goals and local needs," is possible.

Miller, C. A., et. al., "Role of Local Health Departments in the Delivery of Ambulatory Care," *American Journal of Public Health*, Vol. 71, January 1981, Supplement, pages 15-29.

Five health practitioners review the historical involvement of the health department in the total health care system in the United States. The authors contend that since the local health department has traditionally been a guarantor of at least basic medical care for all people within its jurisdiction, a public system might indeed do a better job, not only in terms of social justice, but also in regard to public health outcomes. They believe that, for many reasons, traditional and voluntary provider systems may have limited potential for organizing and sponsoring the required intervention to provide effective health care. Some of the examples given are: (1) poor people, even when introduced into the mainstream of medical care, tend to follow previous familiar patterns of utilization; (2) many private providers prefer not to see poverty level patients—sometimes to protest payment levels or cumbersome documentation requirements, and sometimes out of discomfort in trying to cope with health problems; and, (3) the mainstream medical care system is equipped to serve the middle class. Statistics show that only about 50 percent of all physicians participate as Medicaid providers.

The authors say that studies reveal a substantial increase in utilization of public health sources. Although services are primarily directed toward poverty level clientele, there is increasing evidence that services are being provided across socioeconomic lines. They believe the health department is an important source of medical care, especially as it relates to innovation, preventive services and continuity of care. To support this hypothesis, the authors tested some 15 health departments across the country.

Replete with useful statistics, this report summarizes data on that experiment, with its purpose of discovering, measuring and evaluating the extent to which people, especially children, utilize public provider systems, and the extent to which service is rendered by local health departments. Of particular interest to the authors was the working relationship between the public health department and the private sector. Findings showed three patterned relationships characterizing this working style: (1) the parallel model, no sharing of facilities or staff; (2) the interactive model, a mutually supportive endeavor; and (3) the accommodative model, a joint planning arrangement. Of the health departments studied, some common features found were: professionally strong and personable directors; supportive political environments; and, at least indulgence from the local medical community; and, aggressive resourcefulness in incorporating Federal funds and programs into their own activities.

Both public and private provider systems are essential and can provide mutual reinforcement for achieving universal and equitable health services—all in the public interest, the authors conclude.

Sussman, Gerald E., Ph.D., and Steinfeldt, Lois, B.S., "Capacity Building, Linkages, and Rural Health Systems: the Federal Perspective," ***Public Health Reports,*** **Vol. 96, No. 1, January/February 1981, pages 50-57.**

This is an overview of the organization, function, policies, and initiatives of the Bureau of Community Health Services (BCHS), which is part of the Health Services Administration (HSA) in the Department of Health and Human Services. The article discusses BCHS' primary mission, providing a national focus for efforts to improve the organization and nationwide delivery of health services. It also points out that BCHS has "the lead responsibility for building and maintaining capacity for primary care," and details BCHS progress in making health resources and services available. BCHS, which accounted for more than half of HSA's 1980 budget, was created in the early 1970s because of the recognition that health care needs are often greater in rural areas, but facilities and personnel are fewer than in urban areas. Per capita, rural areas have 58 percent fewer physicians, 38 percent fewer dentists, and 29 percent fewer nurses than urban areas. Additionally, rural areas have higher rates of certain diseases and injuries due to occupational hazards, lower income, larger proportions of young and elderly people, and greater barriers to health care because of geography and lack of transportation.

Among other actions, BCHS identifies rural areas needing health care, provides those areas with technical assistance, integrates categorical program resources locally to form community based comprehensive primary health care centers, and forms linkages to other health service providers. BCHS projects include family planning, child health care, migrant health, and black lung services.

HHS has estimated that its health service delivery programs reach about one-third of the 20 million underserved people in poor areas. BCHS helps to try to reach the remaining two-thirds lacking adequate primary care services and also helps to concentrate health resources in priority need areas. Once health centers are in place, BCHS concerns shift to increasing their service capability as part of a health delivery system by developing linkages to health care providers (i.e., alcoholism and drug abuse programs, mental health programs, and secondary and tertiary hospital facilities providing more specialized care). In addition, BCHS seeks to assure high quality in the services it funds by monitoring centers' compliance with qualitative clinical indicators.

BCHS has made considerable progress in providing populations in need with improved access to various health care services (i.e., community health center services, preventive health services, immunizations, transportation services, etc.). Users of these services are primarily Blacks and Spanish speaking migrants from large, low income families, with equal numbers of both sexes represented. The number of facilities and people served has steadily grown in the past 6 years from 157 community health centers serving 2 million people to 872 centers capable of serving 42 million people. The BCHS migrant projects served 390,000 migrant and seasonal workers in 1975, and served more than 550,000 in 1978.

Stone, Suzanne, "Rural Health Clinics—What Has Happened, What Is To Come," *Forum on Medicine*, November 1980, pages 713-717.

This report examines the changing environment surrounding the Rural Health Clinic Services Act, enacted by Congress in 1977. A major provision of the Act amends the Medicare and Medicaid programs to reimburse rural primary care facilities, i.e., rural health clinics (RHCs), for medical services rendered by physician extenders working under general supervision of physicians.

The author states that although RHCs have improved access to health care, serious problems remain which hamper the program in its efforts to provide service to rural America. She describes both the beneficiary and medical communities as having a suspicious attitude prior to contact with RHCs. Patients were not familiar with the concepts of physician assistants (PAs) and nurse practitioners (NPs), and therefore, appeared to believe that they would be subject to second class medical care. Several instances are cited where patients were hesitant to use RHCs. However, after using RHC services, consumers often became enthusiastic about the level of personal attention received and encouraged others to use the health care services. Also, as physicians were convinced that the RHCs were willing to work *with* them to improve patient care, they began to accept them as valid members of the medical community. The author further contends that "the bureaucracy surrounding the certification and reimbursement processes for RHCs as well as the reimbursement rate have contributed to any failure of the program."

The author discusses HCFA's proposed regulations (*Federal Register,* September 10, 1980) which promise less bureaucratic tangles. These proposed regulations "provide a prospective payment method for Medicare and Medicaid reimbursement of independent rural health clinics." She adds that clinics paid through this method will not be subject to the current reimbursement ceiling of $27.30 per visit. Rather, she says, "HCFA proposes to establish a new maximum rate of 150 percent of the median cost per encounter for all RHCs, and to adjust this rate annually to account for inflation." This rate, according to HCFA, should not add any recordkeeping or reporting requirements for the clinics. Also, the author states that RHCs may soon be able to simplify their reporting systems to satisfy both HCFA and the Bureau of Community Health Services (BCHS) requirements. These agencies are developing a combined reporting system which accommodates each agency's definitions, guidelines and principles. The author believes that this effort toward uniformity and consistency may provide RHCs with increased incentives to be more efficient and cost effective in their operations.

She concludes that these and other Federal efforts, combined with State and medical community endeavors to improve administration and management, may foster an environment ripe for the growth and expansion of RHCs during the 1980s.

"Plus Ça Change," *National Journal,* October 4, 1980, page 1664.

The Committee on the Costs of Medical Care, composed of 48 representatives from the fields of medicine, social science, public health, and government, met over a five year period (1927-1932) to review and evaluate the cost and availability of medical care and services. Their findings were absence of community planning and of integrated services and facilities, overspecialization of physicians, and inappropriate geographic distribution of physicians and services.

In 1974, Congress enacted the Health Planning and Resources Development Act, establishing a network of local and State planning agencies to encourage hospitals to eliminate unnecessary beds and services by sharing arrangements, when practical. However, sharing arrangements have faced the threat of antitrust prosecution and planning agencies have confronted the possibility of substantial budget cuts by a dissatisfied Congress.

In 1978, Joseph Califano, then HEW Secretary, again expressed some of the same concerns identified by the committee in 1932: physician overspecialization, with a decline in primary care physicians, and geographic maldistribution of physicians. Congressional interest in an administration supported bill would tie loans and scholarships to a commitment by young doctors to practice in underserviced inner city and rural areas.

Despite the increase of per capita expenditure for health services from about $30 in 1929 to $943 in 1979, this article concludes that many of the health care planning concerns of 50 years ago continue to be the frustrating issues of today.

Zaretsky, Henry W., "Regulation vs. Competition," *Hospital Forum*, November/December 1980, pages 7-9.

The author, a director of a California health regulatory agency, believes that although a certain amount of government intervention is necessary in the health delivery system, too much government intervention has limitations, causes inefficiency, and prohibits provider innovation and competition. He contends that our needs for cost containment and access can be met by a balance between government regulations and free market competition. The cases for regulation and competition are analyzed and the article concludes with a discussion of a merger of the two approaches.

Mr. Zaretsky explains the reasons for the existence of current health industry regulations—responses to the absence of market forces ("market failure") and pressures by the industry to be insulated from competitive pressures through government regulations. He recognizes the great appeal of competition in today's political atmosphere and the very real possibility of rationing of health care services through government regulations (cost containment) or the free market (ability to pay the market determined price). He also points out that the abandonment of the protections of government regulations would create new incentives for innovative management. He also postulates that, although economic competition in the health sector is gaining in popularity as a long term strategy for controlling health care costs, if the choice was only between competition or regulation, because of the protectionism features, the health industry and consumer groups would opt for regulations. He sees government, business, middle income consumers, and possibly labor, opting for competition because of the cost containment potential.

Mr. Zaretsky suggests experimenting with a phased in approach in a specific area. He recommends replacing cost based reimbursement with negotiated rates, economic competition, and deregulation. This could be accomplished through such actions as: gradually phasing out certificate of need regulations by raising the capital expenditure threshold in increasing steps (e.g., to $500,000, then to $1 million, etc.); gradual deregulation in the personnel licensure area; prior to promulgation, evaluating the impact of all proposed health regulations on competitive forces; and the incorporation of safeguards to guarantee low income consumers sufficient access to needed health services through State and Federal governments contracting with providers, insurance plans, and public and private health maintenance organizations.

Bailit, Howard L., D.M.D., Ph.D., "Issues in Regulating Quality of Care and Containing Costs Within Private Sector Policy," *Journal of Dental Education*, Vol. 44, No. 9, September 1980, pages 530-536.

This paper, which discusses and analyzes issues relevant to the development of policies regarding dental care quality, is divided into five sections. The first discusses the quality of services provided by dentists and their agents, and social factors which increase public demand for improved quality dental care. The second section concerns the quality of restorative dental care and periodontal care in the U.S. and shows that the need for quality assurance systems decreases as the quality of dental services increases. The third section examines the relationship between inadequate quality dental care and oral health, and concludes that much more research is necessary before the relationship between the treatment of periodontal disease and oral health can be clarified. The fourth section reviews the benefits and costs of improving oral health through quality assurance systems and other approaches. The evidence presented raises a cost benefit question by suggesting that only a small proportion of our population have inadequate restorations and, therefore, only this relatively small number of people could benefit from a quality assurance system that would improve the quality of amalgam restorations. The final section considers policy implications and emphasizes the necessity for additional research needed to obtain the information necessary to make informed policy decisions about the issues raised. One such unresolved issue is how to assess the cost effectiveness of improving oral health through quality assurance systems versus the cost effectiveness of alternative methods, such as fluoride rinse programs, dental materials research, or the education of more dentists.

The author asserts there is little empirical information available to validate the claim that the quality of dental care in the U.S. is either deplorable or unsurpassed. However, data are presented which indicate that the great majority of amalgam restorations are properly placed and, as regards periodontal care, overtreatment is a relatively minor problem compared to undertreatment. Studies also show the concentration of periodontal disease in the lower socioeconomic classes due to their poor oral hygiene practices and their limited access to dental services, resulting from their lack of education and affluence.

The paper declares that it is quite possible that quality review systems do not have a major impact on controlling costs or improving health, and this belief has led to Congressional disillusionment with the Professional Standard Review Organization (PSRO) program which, according to the author, has not demonstrated significant savings. The author concludes that empirical data necessary for definite conclusions are not available. Even so, he believes the public would not support the estabishment of extensive quality assurance systems because they would increase, rather than decrease, expenditures. This conclusion is based on findings by the author that only a small percentage of dentists are involved in fraudulent activities, gross overutilization, or other kinds of patient or program abuses.

DiBerardinis, J., and Gitlin, J., "A Holistic Assessment Model for Identifying Quality Care Indicators in Long Term Care," *Long Term Care and Health Services Administration,* September 1980, pages 227-235.

This article focuses on assessment and definition of quality care as it relates to the realm of long term care facilities. The authors judge the basic medical model approach to be inadequate in assuring quality care. Its three basic steps—diagnosis, treatment, and cure—do not consider the total impact of the internal and external environments on the individual. Additionally, they believe the regulations for survey and certification procedures governing the industry are largely ineffective because they measure a facility's capacity to deliver versus actual delivery of quality care. Thus, they set out to establish new standards by which long term care facilities may be evaluated.

The authors begin by developing an information base to allow for better understanding and decisionmaking at the individual and administrative levels. In order to establish necessary criteria for assessing and defining quality care, a literature review was conducted by a multidisciplinary team of professionals. The criteria produced during this review were reduced to 53 independent measures of quality care. Because a pretrial analysis showed that elderly residents were only able to complete about 28 of the 53 factors, the questionnaire was narrowed accordingly. The sample pool comprised 24 of the 71 nursing home facilities serving Medicaid patients in Montana. Also, to assure a wide range of participation, the survey included 99 residents, 9 nursing home administrators, 44 professionals, 74 paraprofessionals, and 18 families of residents.

Findings reveal that no one group of respondents agrees upon a set of indicators that defines quality care. However, the authors report that a definite order of basic needs is identified: "(1) safety (the security need), (2) food (the physiological need), and (3) individual choice and personal identity (the psychological or esteem needs)."

The authors believe that these findings suggest that more time should be spent on upgrading and attending to these basic needs. Further, they urge that the delivery of quality long term care must be directed by systematic, holistic programs as opposed to the current limited medical approach.

Birge, Jack E., M.D., "Controlling Hospital Costs," *Forum On Medicine,* August 1979, pages 516-518.

"The high cost of medical care is a problem of our time, and a serious one," Dr. Birge says. Costs are high not only because of physicians' services, but also because of continual increases in hospital costs. The author dramatizes his point with a hypothetical situation involving a young couple's visit to a hospital emergency room. He compares actual treatment costs against their bill to show that a large portion of costs of medical care provided by hospitals goes for other than those services rendered to the patient.

In searching for answers to high hospital costs, the author looked at the history of a small, rural, 200 bed hospital. He found misguided policies, and costly mistakes made by an authoritarian chairman of the hospital board who knew nothing about hospitals or problems of the sick. The hospital was run from a business viewpoint, and prospered as a business, but without concern for the patients' needs. The hospital's growth was financed out of hospital profits from the sick, instead of taxation of the well, or through contributions.

The author states that the sick should not be burdened with the responsibility of paying for the growth of their community health care facilities; he believes this should be done through taxation. He supports some form of regulatory control and evaluation process over hospital boards and local hospital management to ensure, not only the best of medical care, but the hospitals are run well economically. Dr. Birge states that a system of hospital examination should be established to ensure competent leadership and responsible management, and that physicians should take a stronger stand against rising hospital costs.

"Public Representation on Boards and Blue Shield Allowances: Important Relationship Not Found," U.S. General Accounting Office, HRD-81-31, December 31, 1980.

GAO conducted this study in response to a Congressional request to determine if there is an ascertainable difference in cost containment efforts between Blue Shield plans controlled by public members and those controlled by physicians or other health care provider members. Even though GAO conceded the difficulty of accurately measuring influence or control, they attempted to analyze several factors, including board composition, which might be associated with the amounts a plan would allow for selected physician services. GAO concluded that this study neither proved nor disproved that public representation on the boards of the 64 Blue Shield plans studied greatly affected their cost containment efforts.

GAO did find that higher allowances for physician services were frequently associated with whether a plan had a million or more subscribers and income per capita was relatively high in its service area. Conversely, it was found that as the number of area residents served by a plan and the number of physicians who had agreements with a plan increased, the plan's allowances for physician services frequently decreased. In addition, whether a plan's premium was or was not subject to State tax did not seem to affect physician allowances.

Goldsmith, Jeff C., "The Health Care Market: Can Hospitals Survive?" ***Harvard Business Review,*** **September/October 1980, pages 100-112.**

During the past 15 years, hospital care costs have grown more rapidly than the rate of inflation in general. Federal, State, and local regulatory efforts to contain costs have created competition among hospitals, while alternative health care delivery programs have produced external competition. In addition, hospitals must compete for both patients and physicians, the principle patient supplier. The author identifying these hospital management concerns is director of health planning at the University of Chicago Medical Center as well as lecturer in the University's Graduate School of Business.

A Blue Cross study of plan subscribers showed an 18.6 percent decrease in inpatient days and a 137.6 percent increase in outpatient visits between 1968 and 1978. This situation has created intense pressure on hospital managers to creatively develop effective and profitable utilization of hospital facilities.

Identifying regulations which complicate hospital administration, the author cites certificate of need laws, enacted in 46 States, which require health facilities to secure approval from State health departments before initiating building programs. The 1977 National Guidelines for Health Planning set target occupancy at 80 percent for all non-Federal, acute care hospitals, though many States target at 85 or 90 percent. If target occupancy is not met, a State may deny permission for hospital renovation, replacement, or equipment, thereby restricting a hospital's growth and development.

The author asserts that physician supply may be affected by Federal policymakers' belief that there are too many physicians and that physicians are inappropriately distributed by speciality and geographic location. For example, the Health Professions Education Assistance Act of 1976 significantly restricted further entry into the U.S. of foreign trained physicians who come for residency training and frequently remain to practice.

According to the author, hospital managers can benefit from strategies used by private corporations to protect an enterprise in a maturing market. Counter strategies might include: competing aggressively for physicians, diversifying from acute inpatient care to a broad mix of medical services, developing captive distribution systems to control patient flow, and promoting the institution's services. The author identifies a variety of techniques which hospital managers have already initiated.

Some facilities provide post-M.D. medical education programs and assistance in establishing new medical practices for some assurance that the benefited physician will associate with the hospital. Although these are expensive, the profitable result will be a physician resource and a related patient flow to the hospital.

Service diversification may be created by outpatient or day surgery, freestanding emergency room service to provide episodic health care, and health maintenance organizations associated with the hospital.

Transportation services linked to the hospital can also provide potential patients. However, certain common carrier regulations and the concerns of existing transportation resources must be recognized when these services are planned.

Promotional strategies include a direct patient inquiry referral system to hospital medical specialists as well as special telephone service for area physicians to contact hospital specialists. Both techniques encourage patients and physicians to use the facility.

The author concludes that "the challenge to hospital managers is to deliver new forms of health care." While the not-for-profit, voluntary hospital will be significantly challenged by proprietary institutions, the result may be elimination of duplicative health services and more practical, economical institutional planning. Hopefully, the consumer may be the final beneficiary of these challenges and changes.

"A Report on the Economic Performance of Community Hospitals," *Hospital Performance,* American Hospital Association, Vol. 2, No. 8, August 1980.

This report, prepared by the American Hospital Association's Office of Policy Studies, outlines Market Basket developments since 1972 and gives a projection for 1980 and 1981. It includes graphs showing the growth of the Hospital Market Basket and the growth of hospital components and items of the consumer price index. The Hospital Market Basket is a composite index which measures the effect inflation has on hospitals' goods and services.

Between 1972 and 1979, the Hospital Market Basket increased at an average 8.3 percent annually, with growth during individual years ranging from 5.0 to 11.0 percent. During 1979 there was an increase of 10.5 percent in the Hospital Market Basket, compared to the overall Consumer Price Index of 11.3 percent.

Community hospital expenses in May 1980 were $6.5 billion, an increase of 15.4 percent when compared to a 13.7 percent increase in 1979. Nonlabor expenses increased 15.0 percent and labor expenses increased 15.7 percent in May 1980. Bed capacity increased more slowly to 0.7 percent in May 1980, compared to a 0.8 percent increase in the year before.

Admissions decreased by 3 percent, the first reduction to occur in 17 months. Admissions of under age 65 patients declined 1.3 percent while over age 65 patient admissions climbed to 2.3 percent.

Full time personnel in hospitals increased more rapidly in May 1980 at 4.4 percent as compared to the May 1979 increase of 3.9 percent. Increase in over age 65 patient utilization appeared to follow the same pattern, suggesting that the full time personnel increase was related to the more intensive staffing needed to care for elderly patients.

Components evaluated during the study were community hospital inpatient expenses, labor and nonlabor expenses (supplies, payroll, benefits, etc.), and utilization (beds, admissions, births, etc.).

Breindel, Charles L., Ph.D., "Community Approaches to Developing Health Care Services," *Journal of Ambulatory Care Management,* November 1980, pages 11-22.

This is an analysis of how two small Pennsylvania towns with similar geographic settings successfully used different methods to develop similar health care services. One used external resources, mechanisms, and strategies, while the other relied solely on internal capabilities and self help mechanisms. Five major steps are identified in both approaches: identification of need; assessment of alternatives to meet the need; selection of a method to meet the need; implementation of the plan; and, evaluation of the outcome. The shortage of health care services was first identified in the two towns by residents unable to obtain general practitioner services. The larger of the two towns had limited community involvement, used an outside source to survey community medical needs and potential resources, and utilized outside professional recruitment agencies. The other town eschewed external assistance; its townspeople and hospital staff attempted to recruit physicians through word of mouth and personal solicitations.

When five physicians, including one from Florida, expressed interest in moving to and practicing in the smaller town, a lack of adequate housing and office space intervened. Funds were collected from the community and local industry, land was donated, construction of a medical center and physician's home begun, and residents volunteered their labor. Only equipment and construction materials were submitted for bids. The Florida physician moved to the town, and operated out of a rented home during the year it took to complete facilities.

The larger town developed a Federal grant proposal for a health center. Initial funding was obtained from the State health department, and, with the help of the Regional Health Systems Agency and the HHS Regional Office, Federal grants were obtained for a health center and equipment, and a National Health Service Corps (NHSC) physician was secured. The center's administration and management was contracted out to a regional management group.

The author cites several reasons for the two different approaches. The smaller town was less urbanized, more community spirited and civic minded, with many low to middle income, blue collar workers of less diversified ethnic and religious backgrounds. The larger town was mainly populated with white collar, more highly educated, wealthier people; the town had grown and prospered largely due to the actions of small committees of selected people who were more familiar and comfortable with outside sources of support. The timing of the two cases may also have been a factor. The smaller town's effort occurred between 1968 and 1970, when fewer external funding sources existed, and those available were not well advertised. The larger town's case occurred during the mid 1970s, when Federal and State assistance was being widely advertised and offered to rural communities.

The author concludes his article with two generalizations. First, the knowledge and availability of external resources determines a town's choice of approaches. The second generalization reflects the influence of voluntary community associations. If a voluntary association represents a broad community base, the activities in which it is involved can be integrated into the whole community, support for its activities will be broader, and internal approaches to resolving a town's problems will be more feasible.

Rodin, Arvin E., M.D.; Calhoun, Kevin P.; Bledsoe, S. Delois, "Building Blocks to Comprehensive Quality Assurance," *The Hospital Medical Staff,* October 1980, pages 26-31.

The authors discuss their ideas for meeting quality assurance standards recently introduced by the Joint Commission on Accreditation of Hospitals (JCAH) in their 1979 Accreditation Manual for Hospitals. A new emphasis has been placed on the development of comprehensive studies in quality assurance programs.

The authors stress the importance of planning to establish a good institutional quality assurance program, and for undertaking individual studies within the program. Building blocks for a quality assurance program mentioned in this article are: setting significant measurable standards;

determining the problem's size; writing a summation of the major findings; and, hospital personnel participating in the development of quality assurance studies.

Once a problem is observed and/or identified, the authors point out that a statement of need should be prepared; and to assure conclusive results of any study, intensive recording, tabulation, and a daily log should be completed.

The authors suggest three questions to be asked when reviewing the study conclusions. "Have the criteria been met? If the criteria were not met, did the fact significantly affect the quality of the activity? And if significant, what were the responsible agents or conditions?"

"Federal Funding for State Medicaid Fraud Control Units Still Needed," U.S. General Accounting Office, HRD-81-2, October 6, 1980.

GAO conducted this review to determine whether the establishment and operation of State Medicaid fraud control units has increased States' abilities to investigate and prosecute Medicaid fraud and what actions HHS should take to improve program operation and administration.

GAO found that State Medicaid fraud control units established after Congress authorized an increase of Federal matching funds from the usual 50 up to 90 percent, have increased States' abilities to investigate and prosecute Medicaid fraud. They also found the units have not become self supporting. That is, unit expenses still exceed fraudulent overpayment collections. The 27 fraud control units operating as of December 31, 1979, had identified potentially recoverable amounts equal to only about one half of their operating costs, and GAO questioned the accuracy of the recoverable amounts cited.

GAO identified several hindrances to effective fraud unit operations. These were: insufficient information forwarded to fraud units; problems encountered in hiring and retaining qualified staff due to low State salaries and the uncertainty of continued Federal funding; and inadequate training.

GAO believes fraud units can increase their effectiveness with experience, and recommends that Congress fund the units beyond the September 30, 1980, cutoff date. To receive additional funds, GAO pointed out, units should be required to demonstrate effective performance based on reasonable standards established by HHS. GAO also recommended the development of operational criteria and a fraud unit training manual, and verification of the accuracy of fraud unit statistics.

(EDITOR'S NOTE: *Before its adjournment, the 96th Congress enacted Public Law 96-499, the Omnibus Reconciliation Act of 1980, extending the period for 90 percent Federal matching funds to three years from the date a State establishes a Medicaid fraud control unit, and 75 percent Federal matching funds thereafter.*)

Douglass, Chester W., D.D.S., Ph.D., "Definition of Health Policy Research and Policy Analysis," *Journal of Dental Education*, Vol. 44, No. 9, 1980, pages 517-519.

This article evolved from preparation for the Policy Research Symposium, Annual Session of the American Association of Dental Research, March 21, 1980, Los Angeles, California. The author says that, in an attempt to formulate a basis for discussions addressing the need for more and better information about the development of dental health policy, it became clear that some general agreement on definitions was necessary. To arrive at such an agreement, he explores the terms policy, policy research, policy related primary research, and policy analysis.

To begin, the author defines policy as "a course of action that is adopted and pursued for its advantages." Differentiation was made between public and private sector health policy only as they affect the populations they serve. It is important, the author thinks, to note the difference in results of official policy—formally articulated decisions—and informal activities—what is actually carried out as policy within the organization or government.

Continuing, he defines policy research as the systematic analysis of these formal and informal rules and their impact for the purpose of revising them. He states that policy research divides into two types: policy related primary research and policy analysis. He then defines policy related primary research to be the collection of new data and their analysis whose function is mainly to answer questions about the current course of action, as well as to apply the findings to justify a particular policy decision. The author interprets policy analysis as the systematic investigation of existing data for the purpose of choosing the best policy among a number of possible alternatives and their consequences.

It is important to understand the subtlety surrounding policy analysis for, he believes, it carries a "normative dimension," i.e., one should "know the objectives and underlying point of view of the agency, corporation, government, or professional group under whose auspices the policy analysis is being carried out." Additionally, he advocates scrutiny of the kinds of criteria used to compare policies.

Heatwole, Kathleen B., and Breindel, Charles L., "A Political Paradigm for the Health Care Administrator," *Health Care Management Review,* Fall 1980, pages 67-73.

The thesis of this article is that all health facility administrators must develop political skills and clout to influence health care legislators and regulators to represent provider and patient interests by curbing, or at least influencing, the proliferation of health care regulations. This is necessary, the authors indicate, because Congressional health committees no longer exclusively rely on the medical profession (AMA) and the hospital industry (AHA) as the last word in health related matters, but hire their own "experts" and solicit testimony from varied sources. In addition, many of the new regulatory agencies (e.g., certificate of need agencies and PSROs) have not yet developed ironclad policies and procedures.

Most of this article concerns how health system administrators can develop techniques to influence health care regulations and operating policies and procedures. The many constraints (e.g., IRS regulations, lack of time and money, noncommitment of governing boards, etc.) administrators face are recognized, as is the need for administrators to constantly feed their reactions, opinions, and needs to legislators and regulators. Administrators must have knowledge of Federal and State legislative processes (e.g., when are legislatures in session; which committees deal with health issues; which individuals have the greatest influence on health legislation; what are the Federal and State lobbying and political contribution rules, especially for nonprofit organizations) in order to know when and how to exert influence. It is also recommended that, through visits or the submittal of position papers, administrators offer legislators their expertise, information, and analyses of health issues, including how a bill may affect a legislator's constituency.

Debating at health committee or government agency public hearings is another way of swaying legislators' and public opinion. Stalling bills and proposals through continuing debate and redrafting gains reprieves, sometimes for years. Involving influential legislators in some aspect of an institution's operation (e.g., ground breaking ceremonies, dedications, involvement in board level discussion groups, etc.) also helps gain legislative support. Finally, based on the concept of strength and power in numbers, merging many small hospitals into fewer but larger hospitals, and promoting cooperation (e.g., combined letter writing campaigns and pooling political contributions) is also recommended as means of gaining political influence, rather than differing factions in the health industry competing for attention.

Dolan, Andrew, and Moscovice, Ira, "A Comparison of Hospitals and State Agency Efficiency in Processing Medicaid Claims in Washington State, " ***Health Services Research,*** **Summer 1980, pages 93-104.**

A Medicaid bill processing performance review of the Washington State agency and each of the 109 urban and rural Washington hospitals participating in the Medicaid program was initiated because of complaints from hospital administrators. These administrators contended that they processed bills internally in about two weeks but that public agencies (Medicaid, Medicare, and the State workers compensation program) paid about two months after bill receipt. Rural administrators, in particular, reported that the Medicaid program was tardy in reimbursement, creating serious liquidity problems, and that urban hospitals were favored in bill processing. This project, funded by a National Center for Health Services Research (HEW) grant, was justified because it "presented an aspect of regulations that has seldom been commented upon, and because of the alleged seriousness of the situation for rural providers."

The study considered hospital inpatient bills processed by the Medicaid agency from July 1, 1977, to June 30, 1978. Information captured included number of days between date of provider service and the date of bill receipt by the Medicaid agency (i.e., billing cycle) and the number of days between agency bill receipt and bill disposition date (i.e., processing cycle). Because of recognized distortion to findings, bills without a date of service or with a billing cycle greater than a year were excluded from the study.

The study revealed comparable mean processing cycles for bills submitted by urban and rural hospitals. However, the average hospital billing cycle was more than three times the average Medicaid processing cycle, with urban hospitals having longer billing cycles than rural hospitals. On an average, hospitals took more than three months to submit bills to Medicaid (two months, after excluding bills with a billing cycle of more than one year). In addition, approximately ten percent of all submitted bills were returned to hospitals by the Medicaid agency for further information. Unfortunately, the Medicaid agency did not have information in its computerized system identifying resubmitted bills.

Implied but unsurprising findings were that hospitals submit uncomplicated bills to Medicaid more quickly than they submit complex bills, and hospitals more dependent on Medicaid reimbursement tend to submit bills faster. The study also showed that the Washington Medicaid agency processed bills in about a month and those which took longer tended to fall into two groups: those returned as incomplete or erroneous and those for larger dollar amounts, which probably received closer agency scrutiny. Findings indicated that the State agency reimbursed slightly less than two thirds of the hospital bills within 30 days, if no additional information was required.

The authors concluded that providers "overestimate the State processing cycle and underestimate their own billing cycle" and that "administrators, in the absence of facts, immediately assumed that the source of the problem was not their own institution, but rather in the State agency." The authors stated that "even if the State agency were able to halve its processing cycle, the average turnaround time (i.e., billing cycle plus processing cycle) for bills would be reduced by only 15 days. If hospitals halved their billing cycles, the turnaround process could be reduced by almost 30 days." Finally, the authors summarize: "It is possible that the current criticism of government programs has resulted in deflecting the attention of administrators from possible inefficiencies in their own institutions. A more factually based dialogue could lead those addressing these issues to devise more efficient remedies."

Barey, Polly, T., R.N., B.S.N., and Lewis, Lois, R.N., M.N., C.N.A.A., "Extending Home Care Services: An Experiment That Failed," *Nursing Outlook*, November 1980, pages 680-684.

This is the story of an unsuccessful effort by five small Visiting Nurse Associations (VNA) to form a consortium to offer evening and weekend service because of requests received from hospital discharge planners, clients, and others. The VNAs contacted other home health agencies (HHA) regarding their experiences with expanded services, obtained information about the availability of funds and the need for such services, and estimated the cost of such expansion.

The VNAs made several erroneous assumptions and decisions early on. Some were to: never consider merger as an option; assume the new entity could quickly become self supporting; and, have one person simultaneously perform both functions of developing a new agency and delivering expanded services. Details of obtaining initial funding and staffing are given, as are the problems (e.g., staffing) encountered in starting partial extended visiting nursing services.

Among the problems experienced: only five of 15 aides hired proved reliable; the need for registered nurses could not be met; funds began to run out; and, in spite of the need to generate more visits and revenue, the five agencies couldn't agree on how to provide for extended service hours. The consortium was finally dissolved June 28, 1979.

Reasons for the program's failure are given. Consortium board members were often indecisive. They treated the consortium as a stepchild because they had to spend substantial time and effort on two separate but similar boards. The consortium's coordinator, accountant, and board members spent prohibitive amounts of time filling out forms, preparing materials, and sitting before panels answering questions about certificate of need and licensure requirements.

In spite of the consortium's dissolution, some positive effects were seen. The need for extended service for weekends and evenings was identified, and provided for several months. All five VNAs increased their services. In fact, one VNA now provides nursing and home health aide service seven days a week, 12 hours a day. Communication was established between various board members and agencys staffs. All five agencies established, and still have, seven day a week answering services.

DuBois, Paul M., Ph.D., *The Hospice Way of Death*, Human Sciences Press, 72 Fifth Avenue, New York, NY 10011, 1980.

This 233 page book provides a comprehensive examination of the hospice movement and analyzes the potential impact of hospice on the quality of dying. The author, who developed his interest in thanatology when his wife became terminally ill, describes the hospice movement as it slowly develops into a national network of terminal care facilities. He explores a number of issues: how hospices fit into existing community health and intensive care systems; and, the gap between the needs of a widespread local movement towards hospice care and the Federal government's sluggish response.

Case studies of several established hospices are included. Dr. DuBois discusses the emotional, spiritual and social support of the dying patient, and states that the most common problems of dying patients are pain, nausea and vomiting, constipation, diarrhea, and anorexia. Pain control is the primary goal of hospice care. Staff at Hospice, Inc. say that "50 percent of cancer victims do not experience pain." They also point out that pain controls should be given when the pain is mild, instead of waiting until the agonizing stage. Narcotics, such as morphine and heroin, are used as pain killers, along with additional drugs to control other symptoms of the dying patient.

The author discusses hospitals that provide hospice care and points out the need for community based hospices. He discusses the advantages and disadvantages of establishing hospices in existing hospitals, and describes the difference between care given in hospices and that given in acute care facilities. He states that most hospitals have more beds than are being used, and that other staff throughout the hospital could observe how to care for terminally ill patients. The major disadvantage of using existing hospital beds for hospice care is the difficulty in establishing a supportive atmosphere for terminally ill patients when they are scattered throughout the hospital. Limitations also may be imposed on hospice staff by the traditional hospital physical environment.

The final chapter of this book is devoted to describing the history and structure of the National Cancer Institute (NCI) in Bethesda, Maryland. Dr. DuBois contends that government's support and response to cancer research, prevention, and treatment has been positive, but the Federal response to hospices has been slow. He details this position and adds that NCI's funding priorities should be shifted slightly to provide for followup care, and care for those who are not cured. "Until the interests of the dying and their families are recognized as universal concerns that affect the last stage of all our lives and the quality of life in our society, we as a nation, will continue to die miserable deaths," he concludes.

Dauber, Leonard G., M.D., *et al.*, "Hospice in Hospital: Interdisciplinary Group for Delivery of Care to Terminally Ill in Acute Care (Community) Hospital," *New York State Journal of Medicine*, October 1980, pages 1721-1723.

This article describes a pilot hospice program for terminal cancer patients established two years ago within the Albert Einstein College Hospital, a 400 bed general hospital in the New York borough of the Bronx. Hospice demonstration projects have been set up as separate units in institutions and are usually costly, requiring major funding from government, foundations, or third party insurance carriers. This program, however, did not set up a special unit separate from other patients and does not require special funding or additional hospital costs.

The program is supported by the voluntary efforts of an interdisciplinary team of volunteer and regular hospital health professionals and is designed to help terminal cancer patients and their families cope with the physical, psychosocial, emotional, and spiritual stresses associated with dying, and, if possible, help the patient remain at home. These hospice services begin in the hospital and can continue at home with visits by nurses and social workers providing continuity and support. Also included are six short program case studies.

Brown, Richard E., "Group Practice Management," *Group Practice Journal*, October 1980, pages 21-25.

Group management problems tend to vary in degree rather than type, and solutions are less visible in smaller groups because of the closer relationships of staff and management. The author discusses management problems encountered in group practices and names eight key problem areas group practices face today that will likely intensify in the 1980s. He points out: present and future problems in organization structure and management; management information system design and use in managing resources; group member motivation, productivity, and evaluation; planning and management of financial and human resources; group communication problems; and, Federal, State, and private intervention in the medical care delivery system. The author states the importance of emphasizing clearly defined management roles and objectives, and emphasizes that "The output of the medical care system is a service—an age-old one that faces yet another challenge in the society of the '80s. To paraphrase Peter Drucker once again, it is important to not get caught up in the common alibis for malperformance of service organizations:

- their managers are not businesslike;
- they need better men and women; and,
- their objectives and results are intangible.

The fact is that physician leadership in group practices must accept the responsibility for seeing that these challenges are recognized and met effectively by their managers."

Cassidy, Carl E., M.D., "Licensure by Specialty," ***Federation Bulletin,*** **Vol. 67, No. 9, September 1980, pages 263-267.**

Dr. Cassidy, a Massachusetts endocrinologist, medical educator, and author, believes licensure by specialty, though proper, should not be encouraged because of the complexities and overlapping of the various fields of medicine and surgery. Physicians who obtain "full" licenses in the U.S. can practice as both physicians and surgeons. Dr. Cassidy claims it is impossible to draft legal definitions necessary to address the scope of the practice in which a physician may be licensed and, even if such definitions could be drafted, other problems would still exist.

A good deal of this article concerns Massachusetts' physician licensing statutes, rules, and regulations. Dr. Cassidy points out that in Massachusetts, a physician who passes the Federation (Federation of State Medical Boards) Licensing Examination (FLEX) in one sitting with a FLEX weighted average of 75, is eligible for a full license, even though he/she is not required to have completed any post graduate training prior to the examination.

The article includes a brief resumé of the events leading to Massachusetts' passage of its full licensure legislation and regulations requirements which, in turn, led to the State's mandating certification by a specialty board. Also described are several of the board's licensing rules. The author contends that the creation of new examinations designed to evaluate the results of post graduate programs short of specialization could create licensure problems even more complex than licensure by specialty. Unless there is a compelling need for such examinations, they could be an additional burden for physicians with little or no benefit to the public, according to the author. Dr. Cassidy concludes with a warning that, even though there is a responsibility to monitor all aspects of medicine, we should be aware that laws and regulations lead to more laws and regulations.

Costin, Max, M.D., "Four C's that Can Make a Good Doctor Better," ***Medical Economics,*** **September 15, 1980, pages 69-72.**

The author discusses four qualities that patients interpret differently than their physician. "Knowing the difference can help (a physician) handle problems textbooks never cite," he points out. The four C's are:

Competence—A physician should look at a patient as a person and not as a special kind of problem.

Communication—Use positive words and phrases whenever possible. The correct use of verbal and non-verbal communication is essential to the physician's image.

Concern—A physician should have a therapeutic value of sensitivity to a patient's needs and feelings.

Confidence—Patients want a physician they can trust and rely upon to diagnose and treat their medical problems; physicians should keep their promises and obligations.

Cuatrecasas, Pedro, "The Downward Trend in Drug Discovery," ***Private Practice,*** **November 1980, pages 18-31.**

A pharmaceutical industry official offers his views and opinions regarding today's "dilemma" in drug research and development. He asserts that many potential medicines are not being discovered, developed, or researched because of the enormous investments in time, money, and facilities needed to bring a drug to market. Another reason for the "dilemma," he claims, is the manner in which regulatory agencies interpret and enforce regulations. The absence of drug products, the author submits, increases health costs. He contends that if the products existed, they would reduce not only suffering but also the costs of more expensive therapy or preventive measures.

Over the last 15 years there has been a marked reduction in new drugs and a decrease in new drug testing in human beings. This is mainly because of changes in the regulatory climate, and attitudes fostered by the Food and Drug Administration and other regulatory agencies, the author claims. Increased demands for safety and efficacy data, the proliferation of "the paper maze," delays, and a permeation of hostility and adversarial relationships have discouraged scientists and drug research, he adds. All this leads up to the author's conclusion that the economic viability of return on investment for drug research is threatened, since it costs $40-$50 million and requires 10 to 12 years to bring a new drug to the market. In addition, six to ten years of a new drug's patent life expires before it is approved for marketing, leaving relatively few years to recover costs. Risks are so great, and the economic incentives and rewards for innovation so minimal, that they drive away many potential innovators; those who remain are becoming more conservative and cautious, the author says.

The article concludes with suggestions on how to alter the downward trends and disincentives for new drug discovery. Suggestions include: change patent laws to extend the life of patents through the years needed to obtain marketing approval; make managerial and administrative changes in the FDA to reduce delays due to procrastination, indecision, or bureaucratic maneuvers; establish special tax incentives for research and development expenditures; end "unreasonable" regulatory demands concerning chemistry, manufacturing controls, metabolism, analytic standards, etc., in the early phases of clinical trial because they are usually "irrelevant" for proof of safety and efficacy; and through education, promote greater appreciation by the public and regulatory agencies of the values and benefits of new drugs.

Ludwig, Donald J., "Are Prepaid Plans Ideal for Hospitals?" ***Hospitals,*** **October 1, 1980, pages 71-73.**

This article traces the beginning of the health maintenance organization (HMO) era and examines the impact of the prepayment concept on the "public-general" hospital. Citing earlier controversies to include negative consumer reaction, the author speaks mainly of California's experience in the development of prepaid health plans. Although Contra Costa County Medical Services, a public-general hospital in California, suffered serious drawbacks in the attainment of prepaid health plan status, the author strongly advocates use of the public-general hospital in undertaking the HMO experiment.

The author believes that although the Federal role was a significant and supportive one in the development and organization of strong HMOs, HEW staff analysis left the public-general hospital in a weak developmental position. He argues somewhat against an original posture that a successful HMO-type operation should try to avoid enrollment of large numbers of poor or near-poor members because their ill health status constitutes a fiscal strain which prohibits growth and expansion of the institution. Conversely, he believes that once established, substantial savings are realized through reduced administrative processes. He asserts that "public-general hospitals are ideal vehicles for the prepayment system because they are comprehensive health care providers that can treat large patient populations."

With an eye toward the future, the author states that although national health insurance may question or limit the role of HMOs, the public-general hospital prepaid model can be seen as a demonstration project for an alternative to national health insurance. At any rate, he believes the prepayment concept to be a sound approach to survival partnership. This is true for several reasons. First, he asserts, because approximately 80 percent of the U.S. population have health insurance (including Medicaid) of some kind, the value of a prepaid plan is virtually already being experienced. Second, he contends that "any health insurance scheme that is devised . . . could not curb the present rate of inflation, but would only intensify it." And third, he argues that the real problem in health care delivery as concerns the poor, near-poor—working or unemployed—and the aged, is a limited and fixed means of support.

Gray, Ann, "Guide to HMO-Watching," *Virginia Medical*, Vol. 107, November 1980, pages 764-771.

The managing editor of this periodical interprets the reactions and experiences of a group of northern Virginia private physicians when three health maintenance organizations (HMO) began operating in their area. When they appealed to their local medical society about the siphoning off of patients, the physicians were advised to consider forming their own individual practice association (IPA), a type of prepayment health plan. The article contains descriptions of eight different types of HMOs and a tongue in cheek description of how Federal funds can be obtained and utilized to consider establishing an HMO. Ms. Gray goes into great detail regarding the steps this group of Virginia physicians have gone through (e.g., Federally funded feasibility studies) while considering whether or not to establish an IPA. (No decision had been made at the time this article was written.)

It is pointed out that, as with any business, management expertise and proper money management (i.e., informed planning, oversight, and balancing the cost of dispensed treatments with incoming payments) are crucial to the success of HMOs. The manner in which cash flows in and out of a specifically identified HMO is discussed. How this HMO determines individual physician payments is explained, as is how its money management system encourages cost effectiveness, and how it controls under and overutilization of physician services.

Anderson, Thor E., "An HMO Experiment in Medicare Prepayment," *Medical Group Management*, September/October 1980, pages 40-44.

The Greater Marshfield Community Health Plan (GMCHP) in central Wisconsin is one of 12 HMOs involved in 7 HCFA conducted prepaid Medicare demonstration programs. Enrollment in

GMCHP under this experiment began in April 1980 for coverage effective June 1, making the plan available for the first time to those age 65 and over. By late June, more than one-third (6,200) of the eligible age 65 and over Medicare beneficiaries had enrolled, with enrollment expected to level off at 10,000 by spring 1981.

The GMCHP subscribers receive no bills and covered services are completely prepaid. Interestingly, all physicians practicing in the GMCHP service area are affiliated with the plan, eliminating collection problems from the plan's Medicare beneficiaries. For this reason, physicians accept assignment for 86 percent of their charges for services to GMCHP Medicare enrollees. Discussing capitation rate setting, the article notes that the plan's actuaries estimate Medicare enrollees will cost the plan 3.2 times as much as non-Medicare enrollees.

The HCFA demonstration "seeks to test the potential of capitation financing for delivering cost savings to the Federal Medicare program at no loss in quality, creating incentives for beneficiaries to enroll in HMOs, and increasing HMO participation in Medicare." Research objectives are based on the assumption that "HMOs can provide Medicare benefits at lower aggregate cost than fee for service." The GMCHP, however, has not requested Federal HMO qualification.

The preliminary outcome of this demonstration will be reported after the project terminates in 1982. Predictions are that "a recognized HMO plan can be very attractive to the Medicare population if offered for a reasonable premium rate." It is anticipated that the results of this and other HMO demonstration projects should help Congress with its consideration of fixed capitation financing of Medicare.

Connery, Rev. John R., S.J., S.T.D., "Court Guidelines on Incompetent Patients Compromise Their Rights," ***Hospital Progress,*** **September 1980, pages 46-49.**

This article by a theologist at Chicago's Loyola University discusses the moral and ethical difficulties in deciding whether to use ordinary or extraordinary means to prolong life. It also discusses the difference in perspectives which this decision causes between spiritual and medical practitioners.

Patients have the right to decide if they will use services to prolong their life. The article discusses patients who could not make this decision.

The author presents four cases, including that of Karen Ann Quinlan, and discusses the impact of court decisions for prolonging life when the patient is incompetent to make this choice.

"If a law that is meant to protect patients actually interferes with the exercise of their rights and prevents incompetent persons from getting the relief available to competent persons, something is wrong," Father Connery concludes.

Garanzini, Rev. Michael L., S.J., "WHCF Exposes Four Health-Related Concerns," ***Hospital Progress,*** **Bull. 248, #55, October 1980, pages 10-12.**

Father Garanzini briefly captures the spirit, and the lack of it in several instances, in this article reporting the outcome of the White House Conference on Families which met in August 1980, to prepare its final report.

The Conference's task force of 117 members, advisory committee of 40 and 22 others represented the total 2,000 delegates, and attempted to prepare a report which would somehow show concensus of opinion. This was a challenge, reports Father Garanzini, since some topics evoked such strong emotion that little agreement was possible for the final report. He tells us that the group finally decided that the final report would only address those issues that had been settled during the conference, and omit those unsettled controversial ones. Four major areas expected to be discussed in the report are: The group's ability to deal with sensitive issues; most U.S. families favor a return to meeting social and health services needs within the family structure; the Conference recognized drug and substance abuse as the most "urgently" felt problem facing American families; and, sex and family education is a serious concern, although, the author reports, emotions run strong on the various solutions. While statistics show the results of the lack of adequate information, a controversy exists over who should provide it.

Fagerhaugh, Shizuko, D.N. Sc.; Strauss, Anselm, Ph.D.; Suczek, Barbara, Ph.D.; and Wiener, Carolyn, Ph.D., "The Impact of Technology on Patients, Providers, and Care Patterns," ***Nursing Outlook,*** **November 1980, pages 666-672.**

This article describes the efforts nurses and others have made to identify solutions to problems created by medical technology innovations. The information presented is based on research supported by a grant from the U.S. Public Health Service, Health Resources Administration.

The authors describe the growth of medical specialties, the corresponding evolution of nursing specialties, and the necessary technical specialties which service complex medical equipment. Because technology is continuously upgraded, the authors acknowledge that "the division of labor is constantly negotiated and renegotiated," creating administrative and management problems.

Significant medical advancement has caused a shift in illness patterns, from treatment of infections and parasites to treatment of chronic diseases (e.g., cancer, cardiovascular, respiratory), the authors observe. Medical concentration on treatment of chronic conditions has produced new services "to make up for the incapacitating effects of a disease whose course one is unable to do much about, or to postpone death."

Specialization growth has also produced complex bureaucratic health structures, fragmented health care, and depersonalizing effects on patients. This growth has generated high health care cost, increased government regulations, and moral and ethical concerns. Special interest factions among specialties have generated dissension between specialties.

The writers conclude that "our intent has been to indicate the necessity for a greater awareness concerning how nursing and nursing care are inextricably linked to technology—a linkage which in turn breeds specialized views, to the detriment of common nursing goals." Finally, "the triad of issues—cost, continuity of care, and comprehensive health care for chronic illness—cannot be handled independently; they are interwoven with the issues of safety, morality, and equity raised by technology."

Logue, J. N., Hansen, H., and Struening, E., "Some Indications of the Long Term Health Effects of A Natural Disaster," ***Public Health Reports,*** **Vol. 96, No. 1, January/February 1981, pages 67-79.**

Three health practitioners attempt to support the hypothesis that stress associated with disaster has long term health effects. Spurred by previously gathered information about several major disasters, the authors conducted a study five years after Hurricane Agnes, which occurred in June 1972, causing extensive flood damage to a large part of the eastern and northeastern United States. This is a report of that study. The authors state that its purpose was "to identify the long range health effects of the disaster on a cross section of female residents of the Wyoming Valley." They selected 396 respondents for the flood group, and 166 for the nonflood group. All 562 participants resided in Kingston, Pennsylvania and surrounding towns.

To assure comprehensive information, the researchers utilized a 105 item questionnaire consisting of demographic characteristics, personal experiences in the recovery period, and the respondents' perceptions of the amount of stress in their lives attributable to the disaster, as well as the degree of medical and social support services available to assist them during the post disaster period. Also, they utilized a checklist of 50 specific health problems related to the major body systems, and 10 selected global variables representing both mental and physical health.

Responses of the two groups were compared, and in all instances the flood group consistently showed higher incidence rates of disease than the nonflood group. However, because of the low response rates for both groups, in addition to the fact that the information ascertained rests largely on impressions, the researchers caution against drawing conclusions from this study. It does, the authors say, suggest that the stress associated with disasters may endure for many years and be responsible for excess long term morbidity.

Kirkendall, Walter M., M.D., and Hammond, Jeremy J., M.D., "Hypertension in the Elderly," *Archives of Internal Medicine,* Vol. 140, September 1980, pages 1155-1161.

Health problems of people over 65 years of age promise to dominate the practice of medicine and the delivery of medical services in the near future. This age group currently accounts for 40 percent of all hospital bed usage and 54 percent of every health dollar spent. One significant cause of these health problems is hypertension, a disease that affects approximately 30 percent of the population between the ages of 60 and 65, and 40 percent of those over age 65. Hypertension is the leading cause of invalidism and death in the aged, causing damage to such vital organs as the heart, brain and kidney. It is associated with heart attacks, renal failure and aggravates atherosclerosis.

The authors discuss the different types of hypertension, and the hemodynamics peculiar to the elderly that should be considered when designing treatment programs for hypertension problems. They point out that an increase in blood pressure in the elderly is an expression of a disease process. Results of several studies showing causes and problems associated with hypertension are discussed. These studies are examined to determine whether the prognosis of hypertension in the elderly can be improved by therapy, diet, and drug assistance. The authors say that recent evidence indicates that appropriate therapy delays morbid and fatal complications of hypertension in this group.

Lincoln, Thomas L., and Korpman, Ralph A., "Computers, Health Care, and Medical Information Science," *Science,* Vol. 210, No. 4467, October 17, 1980, pages 257-263.

Development of computer systems for medical science areas has permitted emergence of medical information science (MIS). The tremendous volume of collected medical data has made manual collection, manipulation, and display impractical, so that the use and potential of computers for performing these functions has become essential. Medical procedures, however, are generally presented as patterns or examples which depend on "informal conventions," knowledge and judgment to evaluate exceptions. Since exceptions to routine procedures are frequent in medical science, the procedural exactness of computer systems frequently restricts effective processing of medical information without creating large clerical workloads.

This article uses medical information in the clinical laboratory to demonstrate an effective MIS. Because the laboratory is a well defined separate unit which is simpler than medical practice as a whole, it is an ideal representative of the health care system in microcosm. The article shows that for a clinical laboratory, a computerized system can: structure and screen input; handle bookkeeping tasks; organize, file, and retrieve data; identify unusual results; print specimen labels and produce reports; track specimen status, lab decisions, and quality control checks; and post charges to patient accounts for work completed. The favorable and interrelated results of these functions are: improve timeliness of patient care; improve report format to the physician; provide a data base to improve quality of the health care process; and, introduce management controls for health care cost containment. In this application, potentially significant results could be reduction in volume of unfruitful diagnostic procedures, reduction in incident of treatment-induced complications, and reduction in temptation to act on lab values that may not correspond to or predict illness.

The authors acknowledge that the clinical laboratory represents one of the most successful applications of MIS. However, this example demonstrates that, with enhancements in computer capacity and configurations, the MIS approach has a promising future.

Lind, S. Donna, "Educational Advances in Health Care," *Nursing Homes,* November/December 1980, pages 14-17.

Current long term care issues and available educational programs for long term care administrators are discussed in this article. The author, Assistant Professor at George Washington University's (GWU) Department of Health Services Administration, outlines the long term care program offered at GWU.

The GWU program is designed to prepare individuals for professional careers in managing and planning health services and in developing health related policies. GWU's curriculum includes generalist or specialist education in health services policies and planning, and health services management. Required courses include: Introduction to Health and Medical Care, Organization and Management of Health Services, Program Evaluation, Quantitative Methods, Health Planning, Health Services and Law, Human Behavior in Organizations, Human Resource Management, and Case Studies in Health Services Administration.

GWU students with past work experience or career interests in long term care are given top consideration for Public Health Service Traineeship Awards available from Health Services Administration (HSA). Although HSA programs have reduced or limited long term care residencies because of high cost, GWU is committed to this experience as essential to mastering the complex skills required of the long term care administrator. To increase professional education in long term care administration, a grant was issued by the Health Resources Administration (HRA) to the Department of Health Services Administration allowing for the improvement of long term care speciality courses, the incorporation of long term care materials into courses required of all HRA students, and the development of new long term care residency sites. North Texas State and the University of Arizona have similar programs to that of GWU.

Rom, William N., M.D., M.P.H., "The Rocky Mountain Center for Occupational and Environmental Health," *The Western Journal of Medicine,* September 1980, pages 264-269.

The Rocky Mountain Center for Occupational and Environmental Health (RMCOEH) was established at the University of Utah in 1977. This center has developed innovative training programs in occupational and environmental health, and an administrative structure that may assist other universities developing multidisciplinary programs in the field of occupational health and safety.

The advantage of RMCOEH's location in Salt Lake City, Utah is the availability of resources such as the Occupational Safety and Health Administration (OSHA) analytical laboratories; OSHA's Health Response Team; the National Institute for Occupational Safety and Health (NIOSH) analytical chemistry contract laboratory; the National contract laboratory; industrial hygiene facilities and personnel of Kennecott Minerals; American Smelting and Refining; Radian Corporations; the University of Utah (Colleges of Mines, Engineering, Medicine, Nursing, Law, etc.); and the Department of Family and Community Medicine.

The center's training and technical assistance programs offered to occupational safety and health professions are described. These programs identify and help reduce job related health and environmental problems. The training programs include subjects as occupational medicine (a two year program which provides didactic, research, clinical, and practical training), Industrial Hygiene and Safety (numerous employment opportunities are available in this field), Occupational and Environmental Health (useful for local health officers or environmental health specialists in small colleges, industry, local health departments, or labor), Occupational Health Nursing (this master's program is completed in 18 months to two years; the practitioner program is nine months), and Safety (two bachelor of science programs are offered: occupational safety and health, and public health).

The center conducts research on several work related health problems. Among those discussed in this article are cancer epidemiology, effects on the reproductive system from occupational exposure, immunologic impairments, lung diseases, and health problems related to workers in the field of energy and mining.

There are a limited number of medical schools that have departments in occupational and environmental health. The majority of medical schools have preventive, community or public health departments. The author concludes the article with an outline of the center's administrative perspectives.

M/MMI CLEARINGHOUSE SUPPLEMENT: CATALOGUE OF STATE MATERIALS

(EDITOR'S NOTE: M/MMI published the Catalogue of State Materials *in October 1979; this supplement lists all the State material the Clearinghouse has acquired since then.)*

Alaska Medicaid Manual: A Guide to Accurate Eligibility Determination—This manual provides basic information and instructions regarding recipient eligibility coverage, limitations, and instructions for completing the nursing home income credit form, travel authorization form, and medical authorization coupon. For further information, contact Jeff Hubbard, Division of Public Assistance, Pouch H-07, Juneau, Alaska 99811, (907) 465-3347.

Arkansas Physician's Provider Manual, October 1, 1978—This manual provides physicians with detailed knowledge of the State's Medicaid program policy, billing and claims filing procedures, and program benefits and limitations. It covers recipient eligibility and identification cards, provider participation and disclosure information, third party liability, billing Medicaid recipients, coverage of services and prior authorization, and formal hearings and claims processing procedures. For further information, contact George Roth, Office of Medical Services, Division of Social Services, P.O. Box 1437, Little Rock, Arkansas 72203, (501) 371-2388.

California Medicaid Quality Control/Corrective Action Report, July 31, 1980—This report assesses the quality control performance of California's Medicaid program during the six month review period, April-September 1979 in the areas of eligibility determination, fee-for-service payments, and third party identification. It also includes assessments of Medicaid-related performances of six major aid programs: Supplemental Security Income/State supplementary payment cash aid programs; Aid to Families with Dependent Chidlren; the Medicare program; the California Medicaid only eligibility program (for medically needy and medically indigent); the California Medicaid provider claims payment process; and, the Medicaid third party liability collection process. For further information, contact Frank Randas, Department of Health Services, Medi-Cal Quality Control Section, 1215 16th Street, Sacramento, California 95814, (916) 322-1071.

Delaware Study of Options to Expand Public Health Care Coverage for Delaware Citizens, February 1981—This report gives an overview of Delaware's Medicaid program and health care system, and provides information on various options and estimated costs of expanding State supported health care coverage to needy individuals. For further information, contact Linda Barnett, Division of Planning, Research and Evaluation, Delaware State Hospital, Main Building, New Castle, Delaware 19720, (302) 421-6749.

Florida Billing Guidelines for Dental Services—This manual provides a detailed description of how providers of dental services to Medicaid recipients must file claims for Medicaid payment under Florida's Medical Assistance program. It includes information about Medicaid remittance vouchers, prior authorization, requesting adjustments, voids, and third party liability payments. For further information, contact Lawrence J. Kraft, SDC Integrated Services, Inc., P.O. Box 5050, Tallahassee, Florida 32301, (904) 878-8621.

Florida Billing Guidelines for Physician Services—This manual provides a detailed description of how physicians should file their Medicaid claims for services rendered to medical assistance recipients. It includes information about Medicaid remittance vouchers, prior authorization, Medicare/Medicaid crossover claims, requesting adjustments, voids, and third party recovery. For further information, contact Lawrence J. Kraft, SDC Integrated Services, Inc., P.O. Box 5050, Tallahassee, Florida 32301, (904) 878-8621.

Florida Medicaid Program Billing Guidelines for Noninstitutional Services—This manual provides guidelines on how to file Medicaid claims on the "Request for Payment Noninstitutional-Other" claim form for such noninstitutional services as rural health and home health services, hearing aids and visual services, family planning, and portable x-ray services. For further information, contact Lawrence J. Kraft, SDC Integrated Services, Inc., P.O. Box 5050, Tallahassee, Florida 32301, (904) 878-8621.

Hawaii Annual State Evaluation Report on the Medicaid Program, 1980—A report by the Region IX Health Care Financing Administration (HCFA) Office of their review of the Hawaii Medicaid program. This report gives Federal criteria of the core areas of the Medicaid program reviewed, and the results of Hawaii State performance in meeting these criteria. Core areas reviewed by HCFA included claims processing, third party liability, eligibility determinations, institutional and noninstitutional reimbursement, financial management, administration and management, service delivery, utilization control, fraud and abuse, abortion, sterilization, and family planning. For further information, contact Henry Tyson, Health Care Financing Administration, Division of Program Operations, 20th Floor, 100 Van Ness Avenue, San Francisco, California 94102, (415) 556-6560.

Maryland Insurance Recovery System Procedures Manual, January 2, 1980—This manual provides a description of Maryland's insurance recovery system that is aimed at maximizing the State's recovery of medical assistance funds from third party liability sources. Procedures cover field reporting of insurance information, validation and claims processing, hospital collections, and cash control. For further information, contact Sharon L. Libershal, Insurance Recovery Section, Medical Assistance Compliance Administration, P.O. Box 13045, Baltimore, Maryland 21203, (301) 383-7894.

Nebraska Medicaid Dental Services Handbook, November 1979—This handbook was prepared to assist providers of dental care and treatment to Medicaid recipients. It provides information on the State's Medicaid dental care guidelines and policies, procedure codes and fee schedules, and instructions for completion of forms for reimbursement. For further information, contact Penny Beave, Department of Public Welfare, Division of Medical Services, P.O. Box 95026, Lincoln, Nebraska 68509, (402) 471-3121.

New Jersey Curriculum for Ancillary Personnel in Long Term Care Facilities, October 1981—This curriculum for nurses aides is designed to assist instructors in planning and conducting an educational program at the secondary and adult levels that meets the requirement for nurses aide certification. The curriculum covers the role of ancillary nursing personnel, and the psychosocial, physical, and environmental needs of long term care patients. For further information, contact Martha Posci, Division of Vocational Education and Career Preparation, 225 W. State Street, Trenton, New Jersey 08625, (609) 292-5850.

New Jersey Medical Day Care Manual, February 1980—This manual provides information about the New Jersey medical day care program, including required services, program participation, staff requirements, prior authorization, participant review and evaluation, and billing procedures. For further information, contact Carol H. Kurland, Department of Human Services, Division of Medical Assistance and Health Services, Bureau of Social Care Programs, CN 712, 324 E. State Street, Trenton, New Jersey 08625, (609) 292-1940.

New York MMIS Provider Manual: Inpatient Hospital, June 1978—This manual provides information and guidelines to providers of medical care on New York State Medicaid program billing procedures, policy, and requirements. Subjects covered include: recipient eligibility; inpatient hospital care; alternate care placement guidelines; utilization review; free choice of a staff physician; recordkeeping requirements; and the basis of payment policy. For further information, contact Bernard Noonan, New York Department of Social Services, P.O. Box 1935, Albany, New York 12201, (518) 474-0489.

New York Medical Assistance Core Curriculum, August 1980—This curriculum material is a self-instructional package designed for training use by newly hired medical assistance (MA) eligibility workers. Unit 1 provides the new MA worker with an introduction to the Medicaid program; Unit 2 introduces MA program rules and regulations; Unit 3 explains the use of the MA eligibility desk reference guide; Unit 4 contains information to help determine the Federal or State program category to which a client belongs—such as, SSI, AFDC or home relief; Unit 5 describes the budgeting process used in determining client eligibility through the income and resource process; Unit 6 helps the MA worker develop skills in preparing for and conducting an eligibility interview; Unit 7 is organized to give some basic information about the when, where, what, and how of referrals; Unit 8 helps the MA worker develop skills to work with ill and elderly clients, and the different kinds of medical facilities and support services available for these clients in most communities; Unit 9 orients the MA worker to the work process by focusing on medical assistance from the client's point of view, and describes events and activities that could occur in the course of a work day. This training package also includes a supervisor's coaching guide containing an overview of the entire curriculum module to assist supervisors in answering questions that may arise. For further information about these materials, contact Robert T. Watkins, New York State Department of Social Services, Office of Human Resource Development, 40 North Pearl Street, 12-D, Albany, New York 12243, (518) 473-3915.

Region X Medicaid Report on Program Statistics for Fiscal Years 1978, 1979 and 1980—These reports provide a summary of the Medicaid program statistics for the four States in Region X—Alaska, Idaho, Oregon, and Washington. Statistical data cover the average number of recipients by category and percentage, amount of medical assistance payments, distribution of payments, expenditure for institutional care, screening of EPSDT recipients, sterilization and family planning, and provider participation. For further information, contact Robert L. Tanna, Health Care Financing Administration, Division of Program Operations, State and Contractor Operation Branch, MS 705, 1321 Second Avenue, Seattle, Washington 98101, (206) 442-0543.

Utah Medical Assistance '80: Report of Medical Assistance and County Indigent Statistics, FY 1979-80—This report contains information about fiscal year 1980 Utah Statewide Medicaid services, recipients. It also covers expenditures, and county medically indigent programs and long term care facility expenditures. For further information, contact Leonard Rustad, Division of Policy and Planning, Suite 440, 150 West North Temple, Salt Lake City, Utah 84110, (801) 533-6821.

STATE MEDICAID DIRECTORS' MID-YEAR CONFERENCE

State Practices in Title XIX Program Management

Summary Report

December 2-3, 1980

(EDITOR'S NOTE: *Severe budget limitations preclude publishing a separate report of this conference. We have summarized all of the plenary sessions and included two full presentations.*)

SUMMARIZED AGENDA

State Practices in Title XIX Program Management

December 2-3, 1980

PLENARY SESSIONS

Welcome
Doris Soderberg, former Director
Medicaid/Medicare Management Institute, HCFA

Paul R. Willging, Ph.D., Acting Director
Bureau of Program Operations, HCFA
(now HCFA's Deputy Administrator)

Conference Objectives
Paul M. Allen, Director
Medical Services Administration, Michigan

Keynote Address
Paul R. Willging, Ph.D.—Moderator

Howard N. Newman, (former) Administrator, HCFA

REIMBURSEMENT

Sharon Marcum—Moderator
Director, Office of Medical Services
Arkansas

Alternative Hospital Reimbursement
Pennie Bjornstad, Chief
Bureau of Benefit Payments
Idaho

A Model for Controlling Pharmacy Cost
Thomas Beach, Supervisor
Audit Unit, Medical Assistance Services
Delaware

Pharmacy Reimbursement
Thomas Russo, Director
Division of Medical Assistance and Health Services
New Jersey

PROGRAM VALIDATION

Stephen H. Press—Moderator
Director, Medical Care Administration
Connecticut

Provider Review Sanctions Unit
Mary McTernan, Director
Provider Review and Sanctions
Department of Public Welfare
Massachusetts

State Agency Fraud Unit Procedures
Emmett Johnson, Chief Investigative Officer
State Agency Fraud Unit
Georgia

State Title XIX Agency and Fraud Unit Coordination
Philip P. Natcharian, Director
Bureau of Fraud and Abuse
Department of Public Welfare
New York

Lock-In of Physician and/or Pharmacy Services
Tom Gaylord, Director
Health Care Program Division
Minnesota

ELIGIBILITY

Pennie Bjornstad—Moderator
Chief, Bureau of Benefit Payments
Idaho

Wage Reporting System
James A. Durkin, Director
Office of Audit and Quality Control
New York

Computerized Control of Eligibility Redeterminations
G. Warren Peterson, Director
Systems Division, Bureau of Income Maintenance
Minnesota

Excess Resources Impacting Nursing Home Patients
A. J. Watson, Chief
Eligibility Policy Information Branch,
Medi-Cal Program
California

COST CONTAINMENT

Stephen H. Press—Moderator
Director, Medical Care Administration
Connecticut

Implementing Cost Containment Measures
Robert F. Smith, Assistant Administrator
Medicaid
State Department of Public Welfare
Indiana

A Model for Cost Containment
Clifton Cole, Chief Deputy Director
Medi-Cal Program
California

Title XIX Cost Containment
Paul M. Allen, Director
Medical Services Administration
Michigan

CONFERENCE HIGHLIGHTS

Paul M. Allen—Moderator

Earl M. Collier, Jr.
(former) Deputy Administrator
HCFA

Note: *The many fine workshop sessions of the conference are not included in this agenda or reviewed in the Conference Summary.*

STATE MEDICAID DIRECTORS' MID-YEAR CONFERENCE

CONFERENCE SUMMARY

The Health Care Financing Administration in conjunction with the State Medicaid Directors' Association (SMDA) sponsored the third State Medicaid Directors' Mid-Year Conference, December 2-3, 1980, in San Antonio, Texas. The 205 conference attendees represented 37 States, the District of Columbia, Puerto Rico, and the Virgin Islands; 9 HCFA regional offices; the Baltimore and Washington HHS/HCFA offices; and 55 private sector firms. The meeting theme, "State Practices in Title XIX Program Management," was developed by the SMDA, working through the State Medicaid Group.

Welcoming conference participants, **Doris Soderberg,** (then) **Director of HCFA's Medicaid/Medicare Management Institute,** stated that "the conference purpose is to improve State Title XIX program administration through sharing of State experiences concerning problems, issues, opportunities, methodologies, solutions, resolutions, and frustrations." Describing conference objectives, **Paul Allen, Chairman of SMDA and Director of Michigan's Medical Services Administration,** expressed belief that the conference would "achieve a cross-fertilization and understanding of the various aspects of Medicaid administration and work toward the objective of providing a better managed program."

Dr. Paul Willging, now **HCFA's Deputy Administrator,** found "almost a milestone reflected by this conference" since the sessions were specifically planned to encourage "States talking to States; the people who've had the problems, and subsequently sorted out those problems, are much more adept at being able to provide meaningful assistance to their colleagues in other States." Unlike prior Medicaid conferences, all workshops and plenary sessions, except opening and closing sessions, were presented exclusively by State participants.

Keynoting the conference, the (then) **Administrator of HCFA, Howard N. Newman,** identified the realities facing Medicaid program administrators: "One of the realities is recognition that health is, to a substantial degree, not purchasable. . . . The second hard reality is the relatively simplistic attribution of the fault (i.e., problems in the health care system) at the foot of government, which seems to me to be erroneous, misleading, and not helpful in ultimately solving problems. . . . The last hard reality . . . is the fact that we are obviously reaching the outer limits of what we can afford to spend for health services in this country."

Reimbursement: Idaho, New Jersey and Delaware

The first conference panel discussed **Medicaid Reimbursement.** Panel moderator **Sharon Marcum,** then **Director of Arkansas' Office of Medical Services,** recognized the increased importance of reimbursement innovations after listening "to all of the very sobering remarks about the state of the Medicaid program across the country." She also observed that "we can all identify with (financial concerns) in these times of escalating costs and resources that are more and more limited."

Panelist **Pennie Bjornstad, Chief of Idaho's Bureau of Benefit Payments,** described an **Alternative Hospital Reimbursement** process, initiated with fiscal year 1980. "The hospital can be paid either the amount they would be paid under Medicare (reimbursement principles) or . . . the Title XIX cost limit," whichever is less. Presenting detailed steps for determining the Medicaid cost limit, Ms. Bjornstad concluded that, while the extent of savings is still unknown (projected to be at least $600,000), "at least we won't (spend) more than we used to and, hopefully, we'll end up spending less."

Medicaid Pharmacy Reimbursement was discussed by **Thomas Russo, Director of New Jersey's Division of Medical Assistance and Health Services.** "We firmly believe that cost containment measures should reflect, as closely as possible, practical factors as they exist in the real marketplace." The New Jersey Medicaid agency established a regressive discount formula based on average wholesale price (AWP), permitting the State to take advantage of discounts received by pharmacy providers billing the State $25,000 or more a year. "The regressive discount approach, in our opinion, offers the advantage of equity to providers and the State alike, and is an incentive to the provider to become a prudent buyer, operating within the realities of a free enterprise marketplace."

A Model for Controlling Pharmacy Cost was outlined by panelist **Thomas Beach, Audit Unit Supervisor of Delaware's Medical Assistance Services.** "In Delaware, we believe that the actual acquisition cost (AAC) reimbursement for pharmacies can result in significant savings to the Medicaid program. . . . We acknowledge that AAC is, at least initially, much more difficult to administer than average wholesale price (AWP), but long term, we believe the total program costs are significantly lower and worth the added effort."

Program Validation: Massachusetts, New York, Georgia and Minnesota

Stephen H. Press, Director of Connecticut's Medical Care Administration and Chairman of SMDA's Program Integrity Committee, served as moderator for the **Program Validation** plenary panel. He commented that "in the past and in the present, (some) have indicated that all one needs to do to cut back spending in the Medicaid program is cut back the amount of fraud in that program. I think . . . that is a pipe dream."

Panelist **Mary McTernan, Director of Massachusetts' Provider Review and Sanctions Unit,** described "a few things we've done . . . to control fraud and abuse and a few things we wish we had done." Realistically, she commented that "you really don't want to identify overpayments if you're not going to be able to collect them. . . . " Ms. McTernan offered practical suggestions for successfully developing a Medicaid integrity program. "We developed a handbook for hearings officers and we think it has been very effective. I've had a lot of comments from our hearings officers, saying they've found it a blessing." She also stated that "since I have an audience of predominantly State Medicaid directors, I do want to tell you that the best support that you can give to my counterparts and your managers in charge of your program integrity efforts is a strong set of administrative regulations," and she provided specific issues for regulation coverage.

State Title XIX Agency and Fraud Unit Coordination was presented by **Philip J. Natcharian, Director of New York's Bureau of Fraud and Abuse.** Mr. Natcharian described general principles to assure good cooperation and coordination between fraud control units and the single State agency. These principles included: "good understanding of roles and responsiblities right up front and hopefully, written in (a) memorandum of understanding, . . . (stating) what each party is responsible for doing and what the purpose is; good personal rapport between the staffs; good work (by the State agency) to establish and to protect the credibility of your products; avoid the battle by memo . . . nobody wins; most of all, assure that your unit in the single State agency has equal organization status (with) the fraud control unit."

Emmett Johnson, Chief Investigative Officer for the Georgia State Agency Fraud Unit, described **Fraud Procedures**. "Our goals are simple and two-fold. We want to determine whether or not the complaint is fraud or abuse. If we determine fraud, then we want to document a criminal case, get it prosecuted, get our money back, and terminate the provider from the program."

Reviewing **Lock-In of Physician and/or Pharmacy Services, Tom Gaylord, Director of Minnesota's Health Care Program Division,** stated: "There is no limitation of services for the recipient but the control (of Medicaid services) is sought through the coordination by one primary physician." An independent evaluation of the Minnesota lock-in program in June 1980 revealed that expenditures for locked-in recipients over a two year period dropped between $4400 and $5000 per recipient, with estimated savings from $1.38 to $2.77 for every dollar spent by the State agency. Rates of service were reduced between 35 and 47 percent. Gaylord concluded that "restriction or lock-in is a cost effective program. . . . I think that in these days of fiscal constraints, States would do well to consider at least getting into a relatively small restriction program as a possible means of cost containment."

Eligibility: New York, Minnesota and California

Introducing the panel on **Eligibility,** moderator **Pennie Bjornstad, Chief of Idaho's Bureau of Benefit Payments,** observed that "eligibility is awfully important because that determines who's actually going to get in and be able to use your services. . . . " She also commented that "as you're all aware, in most programs, earned income is the largest culprit in terms of eligibility errors."

The first panelist, **James A. Durkin, Director of New York's Office of Audit and Quality Control,** discussed **New York's Wage Reporting System.** He indicated that "the primary (matching) ingredient to the whole system is the social security number" but also revealed that it is frequently difficult to obtain. The New York agency has found their Wage Reporting System has been cost beneficial, with a return of about four to one for each new segment of the system introduced. "It's a relatively simple system that requires employers to report on a quarterly basis and there are sanctions if they don't report." The State tax department compiles the employee wage information and the various benefit rolls are used to match against the accumulated employee wage data.

Minnesota's G. Warren Peterson, Director of the Systems Division, Bureau of Income Maintenance, described **Computerized Control of Eligibility Redeterminations.** A monthly computerized file is produced for counties, listing cases for redetermination and establishing due dates. "Our disincentive program provides that, when a case is more than 60 days overdue, it becomes 100 percent county liability for all Medicaid costs incurred during the period of ineligibility. . . . ," without Federal or State financial participation. Peterson indicated that county liability has been a significant factor in keeping Minnesota's overdue eligibility redeterminations at a low level.

A. J. Watson, Chief of California's Eligibility Policy Information Branch, discussed **Excess Resources Impacting Nursing Home Patients.** He revealed that excess property is "not the most prevalent case error," but produces "the largest dollar errors in Medicaid eligibility." California has piloted, on a small scale, a search of public property records to identify unreported client property. While the search has involved a small client population, they have found unreported property in four percent of the cases, which the State considers promising. They have also initiated a "more intensive monitoring of clients' statements about their property," requiring verification documentation at the time of application redetermination. He commented that "our QC staff indicates that this should be a cost effective process." Watson advised that "it's important to document the extent and cause of . . . errors, before controls are put on, and then, the extent and cause, after (controls) are put on, so that the deterrent effect of the controls can be substantiated. . . ," when "questions about whether the administrative cost really does pay off."

Cost Containment: Indiana, California and Michigan

Stephen H. Press, moderator of the **Program Validation** session, also chaired the panel on **Cost Containment.** The presentations by **Robert F. Smith, Assistant Administrator of Indiana's Medicaid**

program, and **Clifton A. Cole, Chief Deputy Director of California's Medi-Cal program,** are presented in full at the close of this conference summary.

Panelist **Paul M. Allen** discussed **Michigan's Title XIX Cost Containment Efforts.** He revealed that Medicaid was seven percent of Michigan's budget in 1970 and a little over 12 percent a decade later. Cost containment programs include a mandatory second surgical opinion, beginning January 15, 1980. "We've noticed that in the second and third quarters (1980), we've had a 46 percent drop in hospital admissions for elective surgical procedures compared to the same period last year, before we put in the system." Another innovation cited was equalized fees for specialists and generalists. "We do not pay a specialist any more money than we pay a generalist for the same service." In addition, he described service setting: "If a procedure can be done in an inpatient or an outpatient setting, and there are no extenuating circumstances, we pay less in the inpatient setting than we do in the outpatient setting for the same procedure." He concluded that "we've tried about every initiative imaginable. Some of them have been successful, some of them haven't. . . . Based on the data we have, it shows that we've been very cost effective, so cost effective that our biggest problem now is encouraging providers to stay in the program. It appears that we've promised a service we can't deliver, or, perhaps, a service we can't pay for. This is what happens when revenue goes down and services go up."

Conference Closing

Evaluating this conference and other meetings of Medicaid program leadership, the then **Deputy Administrator for HCFA, Earl M. Collier, Jr.,** observed "that there is just no substitute for requiring people who have to deal with each other to sit around the table and talk to each other and face up to differences and for confrontation." Comparing the evolution of these gatherings, he stated: "I do feel like these conferences are succeeding . . . in their more express purpose, which is to share the wealth, let people know what's going on, get a certain amount of fermentation with respect to difficult issues of implementation of the complex programs that we administer."

Paul Allen closed the session by commenting: "An objective of this conference was to share best practices under Title XIX. . . . I think that's what happened."

IMPLEMENTING COST CONTAINMENT MEASURES

Robert F. Smith

Assistant Administrator, Medicaid
State Department of Public Welfare
Indiana

I am pleased to have the opportunity to discuss with this very knowledgeable group a few details of Indiana's approach to cost containment. We certainly are aware of the necessity for maximizing cost containment efforts, and the mutual advantage to be gained by sharing our experiences. I expect to learn from the other States represented here, and hope that something I have to say will be of value to you. I don't intend to speak as a pioneer in cost containment, but at the same time, we have achieved a certain amount of success which you may find informative.

Before I get into details, I believe you should be aware of the history of our program. From the outset, we have been plagued, in my judgment, with insufficient State staff to achieve the optimum goals that we all seek, and in that, I know Indiana is not unique. We all share the same difficulty obtaining adequate, competent staff to perform even the most essential functions and tasks for the daily operation of our incredibly complex programs. I suppose that explains why we have Medicaid directors and administrators to make decisions relative to priorities in personnel and dollar utilization. In Indiana, I have devoted about 50 percent of my authorized State personnel to various tasks associated with cost avoidance and cost containment. There are a number of aspects in those two broad categories which you may, or may not, agree should be included. One benefit of the joint State-Federal system is that we do have some measure of autonomy in determining in which direction, and to what extent, we will direct our efforts. For the first seven years of Indiana's program, our primary focus was on development and refinement of the claims payment process, culminating in the installation of our MMIS in 1976. Only since 1977 have we begun to adequately address the issues which bring us together today.

Before any single element of the Indiana Medicaid program can be discussed, there are a few basic facts which must be understood regarding Indiana's enabling legislation. Indiana did not enact Medicaid legislation until 1969, so we had the advantage of some other States' experiences when we undertook this task. This experience was carefully reviewed, and it was very clear at the outset that the Medicaid program was going to be costly, certainly more costly than our old vendor payment program had been. The next point which seemed crystal clear was that program restrictions were very hard to handle; they were hard to sell; they made administration next to impossible, and policing, a real nightmare.

As work on the legislation progressed, the drafters realized the tremendous administrative demands placed upon other States as they attempted to determine eligibility, certify providers, establish reimbursement standards, and control costs. In addition, they knew that most States had little experience with claims processing and other comparable insurance functions. Certainly, this was true in Indiana. They knew that in our State there was virtually no experience, and no system, with which to handle those tasks. Needless to say, there were many other problems which surfaced to trouble the legislation drafters, problems which had to be addressed once the decision to enter the program had been made. Foremost among those were budget considerations.

The budget in Indiana, as in your States, is a very serious matter. Indiana is a balanced budget State. By virtue of our constitution, the State can "neither a lender nor a borrower be." Before any legislation could be considered, there had to be sufficient money in the general fund available to finance the proposed program. Any proposed expenditure which will, or can, exceed the general fund reserves, is simply unconstitutional. For this reason, efficiency, economy, and fiscal safeguards had to be built into the program at its inception. In Indiana, provisions for adequate financing, cost containment, and program integrity began long before the enabling legislation was passed.

As a result, several very important decisions were made with these factors in mind. With a balanced budget, you cannot give everything to everybody; so, the State restricted medical care only to the categorically eligible needy. Once this decision was made, the legislators attempted to determine the real needs of these citizens. The answer was clear enough—every health service any other citizen requires. The legislature responded to this need by authorizing the Indiana Medicaid program to make reimbursement for all medical services for which Federal financial participation is available, now more than 20 services. This generous position was adopted in 1969, and with the exception of excluding payment for family planning abortions, the position remains the State's statutory policy to this day.

Our program is "physician driven." Services are reimbursed on the basis of medical necessity. In many ways, the program's broad scope avoids many of the administrative difficulties experienced by States with extensive program limits. There are no problems with coinsurance provisions, deductibles, services being limited to children or the aged only. The result is that both recipients and providers can more easily understand how the program works, and what services are covered, which is very helpful to all involved. A most valuable by-product has been a general willingness of providers, as groups and as individuals, to participate in our program.

It was envisioned that the Indiana Medicaid program would be an insurance program which recipients could use in the same manner as you and I use our private insurance. Services would be delivered by the private sector of the medical community, with the recipient choosing the providers according to personal needs and preferences. The extensive problem of potential overutilization and abuse, perhaps, did not receive adequate attention during the planning and development of the program. I believe that is true of many of our sister States.

Another basic decision reflecting the conceptualization of Medicaid as an insurance program was the decision to accomplish many functions through the use of a fiscal agent, rather than by expanding the State staff or increasing the number of State owned computers. In Indiana, the fiscal agent contract includes: institutional rate setting; claims processing; surveillance and utilization review; medical review; provider audits; and other functions. Over the years, we have found that all of these tasks require far more State personnel, and more State and county involvement, than was originally expected; however, the department feels the contract method has served the Indiana Medicaid program well and has kept the State payroll under control. We consider fiscal agent contracting to be one of our major cost containment efforts, and have just selected the successful bidders for the 1982-1984 period.

The decision to award a fiscal agent contract influenced the development of Indiana's Medicaid program, in general, and, in particular, the development of automated claims processing and the automated statistical and information generating subsystem. The Indiana Medicaid program has been automated since the beginning, with prepayment parameters, duplicate billing edits, and eligibility data, including third party resource information, audited for each claim. The system underwent a major advancement when Indiana implemented MMIS in 1976 and will undergo yet another series of major enhancements in 1982. The potential for cost containment was a major factor in deciding which changes to incorporate in our next contract. The use of a fiscal agent and automated systems have contributed significantly to the State's ability to monitor and control program costs. The automated system is valuable, of course, for efficiency, accuracy, and the ability to provide management information. Another capability which is even more important is the system's ability to communicate. Not only does the system tell the State and the providers of service the status and/or disposition of each claim, it also tells the recipient how much was paid to whom, and for what, and the service date. Indiana's MMIS system generates a monthly Explanation of Medicaid Benefits (EOMB) for each recipient. The EOMB, attached to the Medicaid card, requests the recipient to identify any benefit irregularity on the EOMB and return it to the State. We use 100 percent coverage, as opposed to the optional sampling provided by Federal regulations. This constant communication with every recipient has proven to be a valuable resource, as recipient responses often point out systems problems, or may raise questions concerning potential fraud and/or abuse. Interestingly, many recipient responses complain about the high cost of services.

These introductory remarks were intended to acquaint you with some of the diverse elements which have guided the program's evolution. As you may have gathered, many cost containment measures are already in place and the State continues its efforts to perfect the available tools, and to implement additional measures which demonstrate cost containment potential.

When we look at cost containment, two major categories are considered. They are, first, cost avoidance and, second, cost recovery. We define cost avoidance as the prepayment activities, because the program funds are not spent in the first place or because the amount of reimbursement is limited. As an essential corollary, cost recovery, or "post payment" activities, take place after payment has been made. Both cost avoidance and recovery activities are handled through a combination of various automated and manual techniques. We are convinced that the cheapest, most effective approach to cost containment is automated cost avoidance. Our current contract, and many of the proposed changes to the next contract, take that fact into account.

As one example of our automated cost avoidance techniques, I'd like to mention just a few of Indiana's numerous prepayment parameters which either limit reimbursement or prohibit improper payment by identifying, at the very outset, claims for manual review.

(1) There is a dollar limit on physical therapy per nursing home recipient, for each admission.
(2) A transportation claim is manually reviewed when a recipient uses more than a specified number of ambulance services per month.
(3) Many surgical procedures are limited to one per recipient for life. This parameter may sound strange, but who needs more than one appendectomy in a lifetime?
(4) Claims for more than four skilled nursing home visits by a doctor, per recipient, per month will pend for a medical necessity review.
(5) When there is a claim for more than one physical examination per recipient, per year, the second claim will reject as over the coverage limit. Claims for more than one set of glasses issued to a recipient per year will also reject. Each of these claims is then subject to manual review for determination of medical necessity.

As mentioned earlier, some prepayment edits require that the claim merely be reviewed for medical necessity, while others will prohibit payment and reject the claim. There are nearly 50 such automated prepayment edits. These edits rejected, or caused a medical review of, more than $160 million in claims in FY 1980. The actual cost avoidance amounted to approximately $40 million.

Another set of very effective automated cost avoidance edits can be found in the enrollment file, which contains identifying data and eligibility information for every recipient enrolled in the Indiana Medicaid program. The enrollment file contains sufficient space to code three insurance policies per recipient. The Indiana Medicaid card also carries these three codes, thereby alerting providers that there is additional coverage which should be billed before Medicaid. If the provider fails to indicate that the other insurance coverage was billed, the claim is rejected. The Explanation of Medicaid Payment for the rejected claim will advise the provider to first bill the other insurance carrier or government program. Included in the third party liability resource codes is a temporary code which indicates that the recipient sustained injuries as the result of an accident. All claims are rejected for other insurance while the code is in place, unless the provider specifically indicates that either the other insurance will not pay or that the claim is not accident related. These third party resource edits avoided over $86 million in costs during FY 1980.

The enrollment file also includes a level of care indicator for long term care which can be placed on file only by the State. This ensures that the State's preadmission review process is completed before payment is made to long term care facilities, and that only the proper level of care is reimbursed. Associated with the level of care indicator is a three line field for personal resource contributions made by the recipient to the facility. Since the amount for which the recipient is liable changes frequently, the date and the applicable amount are recorded. When the field is full, the oldest information is removed so a new entry can be made. Historical information, however, is retained on microfiche, should it be needed at some future date.

Indiana also participates in the buy-in and BENDEX programs and has a State Data Exchange. This information is primarily used to alert and verify to county departments the amounts of other resources to be applied in determining appropriate eligibility. The buy-in information is recorded in the enrollment file and is accessed during claims processing to assure proper Medicare processing and payment prior to Medicaid adjudication.

The enrollment file records whether a recipient is restricted to a particular provider and service(s) for a specific period of time. This is done primarily for certain recipients to prevent drug abuse or provider shopping, and prevents both inappropriate services and unnecessary payment. The identification cards are generated with the restricted information shown on the reverse.

We have now discussed two major files within the MMIS system in considering automated cost avoidance techniques. The prepayment edits are located in the claims payment file, and the resource edits are in the enrollment file. Since the prepayment parameters rarely change, they present few problems. The resource information edits in the recipient enrollment file, however, change rapidly for many of our individuals. To add to the complexity of the problem, 92 counties and a State unit must supply the information required to maintain an up-to-date enrollment file. In addition, my division adds information regarding level of care for nursing home recipients.

To facilitate updating the enrollment file, the State installed a 15 county direct data entry system which covers 50 percent of the welfare population. The installation of the on-line teleprocessing system has been one of the most exciting developments in our Medicaid program. In addition to speed and efficiency, it is the best training device we ever gave the county departments. The 15 counties with teleprocessing terminals get immediate feedback for each data entry, plus the capability to query the system regarding any recipient's enrollment data. One of our largest counties, on its own initiative, researched every recipient's record and literally overhauled its entire enrollment file for both active and inactive cases. The State is so impressed with the counties' ability to upgrade the integrity of the enrollment file through the teleprocessing terminals that we intend to provide terminals for 95 percent of the population in our 1982-1984 contract. Actually, all of the counties have derived great benefits from the teleprocessing network. The smaller counties which do not have their own terminals handle a great many problems by a phone call to the State. The State consultant can query the system, using terminals in any office, and spot a problem quickly. Instructions can be given to the county, if paper transactions are appropriate, or the State can enter emergency transactions on the spot. When emergency entries are made, the counties are required to provide written documentation, explaining the reason for the request. Each time a correction is made, the potential for costly error is reduced. It is difficult to estimate the savings generated from the teleprocessing system. We do know, however, that as the number of county initiated updates has increased, the number of complaints from counties, recipients, and providers has decreased, and the need for a number of prepayment edits has diminished.

Automated cost avoidance techniques also are applied to the provider file. They may be used to pend payments, to side-track claims for manual prepayment review, or to prohibit payment to providers who voluntarily withdraw, are temporarily suspended, or are excluded from further participation. We keep an ongoing, automated record of both provider payments and adjustments to these payments against which all claims are processed and all reporting is done. Payments are made against a full and updated file history at all times.

As mentioned earlier, the State is most impressed with automated cost avoidance techniques. Used in conjunction with our payment profile system, the average monthly cost avoided by their use is in excess of $10 million, or approximately 25 percent of the amount billed to the program each month. The State also uses manual cost avoidance techniques in the management of the program. Prior approval is required for items of durable medical equipment, certain surgeries, certain dental benefits, and non-emergency, out-of-State care.

I already mentioned the State's preadmission review for long term care when discussing the enrollment file and I believe it deserves a more detailed description. Our preadmission review is a complex program which requires statements from both the county welfare department and the attending physician. All documents are reviewed in my office by medical personnel who apply the State's level of care criteria in determining the proper reimbursement level. The review determines whether reimbursement will be made for skilled care, intermediate care, inpatient psychiatric care, or care in one of the various ICF/MR settings. Approximately $250,000 in inappropriate costs were avoided during FY 1980.

Another example of a manual cost avoidance effort is prepayment review for medical necessity. Indiana makes extensive use of a system to review selected provider's claims for medical necessity. Such a prepayment review is initiated when information available through SUR, investigation, or audit determines that a provider may be submitting unnecessary claims. A provider placed on prepayment review for medical necessity has all claims reviewed by medical personnel to determine if the diagnosis corresponds to the service provided, and whether the service provided meets the criteria of medical necessity. In FY 1980, nearly half a million dollars in costs were avoided as a result of reviewing selected claims for medical necessity.

We do not consider the savings data an accurate reflection of the efficiency of these programs, as we believe they also have a significant deterrent effect which cannot be measured. In addition to avoiding costs, these techniques provide a vehicle for constant communication with the provider and the county welfare departments. Twenty investigators, auditors, and medical personnel are in the field checking alleged irregularities. The ability to communicate is seen as a positive public relations endeavor and as an opportunity to continue the State's educational efforts with both the provider community and the county departments. Because the need for communication is vital to all involved in the program, the State recently has rewritten the county enrollment manual and all of the provider manuals. Also, we recently published an accounting manual for nursing home operators which we believe will be of great value to Indiana's nursing homes, and will standardize their reporting procedures, thus easing our audit task.

The State has a separate contract for the full scope audits required by Federal regulations. The contractor is required to audit one-third of Indiana's long term care facilities each year. The findings are, of course, useful in identifying potential fraud as well as in rate-setting determinations, which again helps the State's cost avoidance efforts. Full scope audits, like all others, occasionally require additional investigation. When this occurs, followup activity may be handled by the State, the fiscal agent, or both, depending upon the nature of the case.

There are many other manual cost containment methods which are utilized in Indiana. We have always provided reimbursement for second, and even third, medical opinions. We also maintain a nine percent annual ceiling on nursing home rate increases. The State, through the fiscal agent, has signed Memorandums of Understanding with the various PSROs who conduct onsite medical reviews and independent professional reviews in nursing homes. We believe the onsite reviews, when combined with the preadmission reviews, give Indiana a firm control on level of care.

As part of the onsite medical review and independent professional review, and commencing with the 1982 Medicaid contract in Indiana, the automated system will produce a report of therapy utilization for each long term care facility. The reviewers will use this report to check therapy services while performing the review in the facility. The report will summarize overall facility billings for the year to date and attending physician billings and therapists' billings for services through that facility for recipients. We feel that therapy services are some of the most difficult services to monitor in a long term care setting and should be subjected to some scrutiny, particularly for maintenance therapies.

This list, of course, is not all inclusive. I have not mentioned the State's new drug reimbursement methodology or a current contract with Purdue University to study prescribing patterns for nursing home recipients to determine an equitable pharmacy dispensing fee. While these topics may be interesting, the State's endeavors in these areas are relatively new. Since there is no concrete cost avoidance information available, I will defer comment on these very promising program developments.

There are, of course, a number of manual recovery or postpayment activities which are vital to the integrity of the program. Indiana maintains an extensive, comprehensive audit program. Each year the fiscal agent completes desk reviews of the top 600 providers. The providers are identified by the automated SUR system, and the review includes analysis of all applicable SUR reports, plus a review of randomly selected claims for each of the 600 providers. The current fiscal agent contract requires that all categories of service be included in the 600 desk reviews; therefore, a selection from each provider group is reviewed.

The fiscal agent also is required to perform 180 randomly selected onsite pharmacy audits. These, combined with 600 desk reviews and 140 nursing home full scope audits, allow the State to keep very good control of the providers. The SUR system also produces exception reports on recipient utilization and the fiscal agent is required to perform 100 recipient desk reviews each year. In FY 1980, the fiscal contractor audit program identified about one million dollars in overpayments.

The fiscal agent's contractual audit obligation requires four man years, and any time not consumed in the mandated activities is available for further indepth audit or investigation. The State and the fiscal agent work together in regularly established priority meetings to determine how this additional capability will be used. The State maintains a force of seven auditors and twelve investigators, plus a research unit of six staff members, to follow up on problems brought to the State's attention as a result of the desk reviews, audit, or through other means. The State recovered more than a half million dollars during 1980 as a direct result of State audit activities. Of course, monies are not always collected in the year that they are identified. The State expects the total recoveries to continually increase as the result of resolving lengthy cases already under development.

In Indiana, we have become increasingly aware of the potential uses of the SUR subsystem. Its complexity requires considerable effort to properly understand the diverse uses of the system, and we have been devoting more personnel to analysis of the SUR reports. We have found that the SUR parameters must be continually evaluated and refined to ensure that the reports are of maximum benefit. We have taken the initiative to make the SUR subsystem more useable and effective through requirements outlined in our contract for 1982-1984. We believe in the SUR and believe we have only begun to tap the potential of the system. We use it in a variety of ways to develop better utilization management of both providers and recipients. It can be used not only to identify potential fraud and/or abuse, but also to educate providers and to identify necessary policy changes.

Recently, we added a doctor and a registered nurse to the Program Integrity staff. Charged with the responsibility to review our SUR data, these medical personnel will provide an additional dimension to the efforts of our investigative/audit staff. We believe their expertise will be invaluable in our effort to properly manage the utilization of Medicaid services.

Postpayment techniques are also employed to identify recipients with unusual utilization patterns. When these recipients are identified, a field investigation is done by my staff. We frequently find doctor or pharmacy-hopping, drug abuse, or inappropriate use of hospital emergency rooms and transportation services. Some of these cases are referred for prosecution, while others are handled through counseling and county monitoring. If counseling fails, or if the recipient is referred for prosecution, the State will restrict the recipient's use of the Medicaid card to one doctor, one pharmacy, and one hospital of the recipient's choice.

Indiana has one totally manual postpayment recovery program which I would like to discuss. The State maintains a Third Party Liability Unit as part of our Program Integrity Section. This unit recovers monies from health insurance carriers when coverage is discovered after Medicaid reimbursement has been made. Additional third party resources may be discovered as the result of an investigation, a quality control referral, or an update report from a county department. Occasionally, recipients advise us that they have other resources. This usually occurs when a recipient finds Medicaid payments on their Explanation of Medicaid Benefits and writes back, advising us that

Medicaid should not have paid the bill. Recipient participation in third party recovery efforts has been most helpful and this is one of the major reasons we elected to retain 100 percent use of EOMB.

The Third Party Liability Unit recovers money from casualty carriers, or settlements resulting from litigation for accident related medical care. Casualty cases often come to the State's attention through what we refer to as the High Value Claim Program. Starting in 1978, the fiscal agent was asked to forward copies of all claims for $10,000 or more to the Medicaid Division. We investigate every claim thoroughly to determine if other third party resources are available. This program has been so successful that late in 1978 the dollar amount was lowered from $10,000 to $7,500. The only reason I haven't yet further lowered the amount, and increased the number of claims reviewed, is lack of personnel to do the checking. I'm looking at ways to correct that problem. As might be expected, many of these high value claims involve accidents with subsequent litigation. Many take years to reach resolution, so we don't anticipate being able to measure the real payoff until 1981 or later. We are sure, however, that the more rapidly these cases are identified, the better the chances for recovery. Although the Third Party Liability Unit is relatively new, it recovered or caused to be recovered more than three-quarters of a million dollars in FY 80. In 1982, effective with our new Medicaid contract, the claims system will produce a regular report identifying potential third party liability recoupment as a result of accident occurrence. This will be used to identify potentially high dollar recoupment, and will be based on accident-related trauma codes.

An additional $325,000 was recovered in 1980 from other sources. This includes more than $150,000 from institutions and individual providers who, for one reason or another, had lost their license or JCAH accreditation. Another $175,000 was retrieved from miscellaneous audits and investigations, including some refunds actually handed to our field investigators on the spot. These are monies handed to reluctant investigators by providers or recipients who preferred handing it over rather than mailing it to the appropriate State department. This money is best categorized as an inadvertent recovery and these recoveries seem to be on the rise. Not all such recoveries are gathered in the field, however. Sometimes providers discover errors and refund money independently. Some recipients send unsolicited refunds to the program and, on other occasions, insurance companies pay the program, instead of the provider, when they receive claims for known Medicaid recipients.

The Third Party Liability Unit also is involved in an effort to maximize the application of Medicare funds. The staff is currently checking the BENDEX file against the enrollment file to identify recipients who are entitled to Medicare benefits, but do not have this resource coded or have not been "bought in." Counties are notified by letter when these recipients are identified, and the State staff monitors the enrollment file until it is properly updated.

Our department sought and received permission to bill Medicare for Medicaid paid claims which should have been, but were not, billed through Medicare. When the staff identifies a recipient whose enrollment file was not properly coded for Medicare, we then research the claims history file to identify inappropriately paid claims. Hard copies of the claims are provided by the fiscal agent, and the State then completes and submits the Medicare claim form. This effort is so new that the State has not had the opportunity to evaluate it. While data collection is only partially completed, we have identified more than $30,000 in claims for one county alone for the year of 1980. If Medicare accepts liability for the majority of these claims, as they have stated they will, we believe this effort will prove cost effective and add considerably to the State's recoveries.

The Medicaid claims/MARS system generates a provider category summary each month, which is used to chart changes in expenditures in all areas of service. Any areas experiencing sudden or unexpected fluctuations are targeted for more extensive analysis and potential policy changes. Under our new Medicaid contract for 1982, this report will be expanded to show unduplicated recipient participation in each category of service and per diem payments by institutional facility types, and will bring all these monthly totals into year-to-date totals for each service category.

The Indiana Legislature, faced with an incredible increase in the budgetary request for Medicaid in the 1982-83 biennium, has begun to look much more closely at our program. They have asked that we identify those options we may consider viable in reducing expenditures. The Indiana Medicaid budget may not be significant in comparison to some larger States but, as I explained earlier, we *must* maintain a balanced budget.

We are currently studying a proposal to significantly expand our prior approval program, through promulgated regulations, and to enact a copayment system. We expect to be mandated to take action in both of these areas. The prior approval program was, in fact, designed in 1977, and regulations were written, but, because fiscal restraints were not receiving their current priority, they were never approved. Now, with a Medicaid budget of $600 million projected for FY 1983, the Indiana Legislature is taking a much deeper, more critical, look at methods to reduce our projected expenditures.

In summary, I believe that Indiana's cost containment efforts are comprehensive, responsive to Federal directives, and are an essential productive part of the Medicaid program. As a result of these efforts, we look forward to enhanced management, continued viability of the program in an era of austerity, and increased critical and intense review by legislators and the general public.

A MODEL FOR COST CONTAINMENT

Clifton Cole

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California

When I accepted the invitation to address this meeting, I had little indication that our national political environment would be undergoing such a dramatic change in leadership. I wanted to share with you the fundamental principles upon which the California cost containment strategies are based. While the election has not altered my thinking on these issues, it has definitely caused me to seriously reflect upon what the opportunities and changes will be in the context of a Republican administration. Not only will there be a new President and his administration, but Congress has also significantly changed. As you know, the Senate is now constituted with a majority of Republicans and many more Republicans have been elected to the House.

While I do not regard Republicans as the enemy—or even as adversaries—I do believe we will all be rehearing and revisiting some approaches generally favored by Republicans, such as closing the current open-ended appropriation, limiting the rate of growth, converting to block grants, requiring copayment, perhaps eliminating beneficiary freedom of choice of provider, and, definitely, reducing government regulations to encourage less government and more private industry.

I cannot emphasize too strongly how critical alternatives are in the face of a closed appropriation or block grants. In that context, States must demand the flexibility to use all available tools to assure efficient expenditure of very limited dollars. The absolute key is for States to have the flexibility to meet the individual circumstances of its own State, and within regions within the State. If the States do *not* have this flexibility to become prudent buyers of services, to use organized health systems more extensively, or to find new ways to shift costs, we will be forced to the more tragic recourse of reducing needed services and preventing the poor from having access to adequate care, even more than we have already done.

The major problem with the current system is twofold: the manner in which the health care system operates and the manner in which government has chosen to implement the Medicaid program.

Professor Alain Enthoven of Stanford University has said: "The main cause of unnecessary and unjustified increase in costs is the complex of perverse incentives inherent in our dominant financing system for health care: fee-for-service for the doctor, cost reimbursement for the hospital, and third party insurance to protect consumers, with premiums usually paid entirely or largely by employers or government. This system rewards providers of care with more revenue for giving more and more costly care, whether or not more is necessary or beneficial to the patient. It leaves insured consumers with little or no incentive or delivery plan." (Enthoven, A.C.: "Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There from Here," *National Journal,* May 6, 1979.)

The fundamental problem of eligibility restrictions—which do indeed represent a very powerful method of containing costs—is that they reduce cost to the Medicaid program simply by ignoring need in the indigent population, and shift the burden of meeting that need to either local government, private charity, or the individual. Although it is possible that some eligibility criteria in some State Medicaid programs have been too generous, in general, restricting eligibility runs contrary to the very mission of Medicaid, which is to assure that lack of personal financial resources does not inhibit access to necessary health care.

Restricting the scope of benefits presents the same dilemma. Some Medicaid programs, for example, presently will pay for only 21 days of acute hospital care per year. This means, of course, that individuals in a catastrophic medical episode—the ones who most need the help that Medicaid was intended to supply—become the burden of either local government or private sector charity. Another problem with the strategy of containing costs by restricting benefits is that it may simply cause a shift to higher cost methods of treatment. The classic example is outpatient pharmaceutical services which, in terms of Federal regulations, are optional. Eliminating drugs from Medicaid coverage, however, would almost certainly lead to a significant increase in hospital admissions. This would be partly due to attempts to obtain needed drugs, and partly the result of medical complications that can be avoided with proper outpatient drug therapy.

Constraining provider payment rates has not proven to be an effective cost containment mechanism. In the first place, in most Medicaid programs, about 60 percent of the health care dollars are being paid for hospital inpatient services or nursing home care for which reimbursement must, by Federal regulation, be related to actual cost. For these provider types, the general rule is that as costs go up, reimbursement goes up. States can be—and have been—much more arbitrary about payment rates to pharmacists and physicians, but here again, the payment of low rates can have the same effect as restricting benefits. That is, providers refuse, in increasing numbers, to participate in the program, causing a shift to more expensive settings as the source of health care services. As physicians drop out, for example, hospital emergency rooms become the source of primary care, where the cost may be three or four times that of equivalent services received in a physician's office.

It is in the area of administrative control measures that States have been most creative with their cost containment efforts. It is common, now, to have elaborate computer systems for processing claims from providers, so that each claim is subjected to literally hundreds of edits to assure that the service was appropriately rendered. In addition to the detailed questioning of individual claims by these automated surveillance and utilization review systems, the computer programs retrospectively examine the entire Medicaid practice of providers over the preceding year or 15 months. Detection of abnormal practice patterns by this computer system will cause the provider to be examined more closely for possible fraud and abuse, often through an audit of his or her medical records.

In addition to these automated control measures, many States require prior authorization for expensive services. In California, for example, it has been the practice since 1970 to require prior authorization by a physician, employed by the State, for all nonemergency hospitalizations and for emergency hospitalizations beyond three days. Some States have investigators posing as Medicaid beneficiaries in order to obtain direct experience with the manner of practice of physicians and other providers.

In short, the States, in attempts to control the escalating costs of Medicaid, have, over the years, developed extensive procedures for second-guessing the professional judgment of physicians and for probing the fiscal and medical records of physicians, hospitals, and other providers. These invasive techniques, together with generally low payment levels, drive physicians out of the program, reduce beneficiary access to physician care, and as we have already noted, force beneficiaries into use of hospital emergency rooms—usually in city or county hospitals, which cannot turn them away. The physicians who do remain in the program tend to be those who have learned to beat the system, including those who operate "Medicaid mills." The result is that quality suffers, costs continue to increase, and the States, in turn, respond by inventing new ways of intervening in the health care process.

To summarize, we are convinced that the Medicaid program that we have all come to know and some of us love, is the direct result of an unfortunate marriage of two concepts: the "credit card" concept, which gives unlimited purchasing power to the poor, and the fee-for-service concept, which is a cost plus system, preferred by the health care industry. With this combination, attempts to contain costs produce more frustration than they do savings. The provider community and the government administrators engage in endless iterations of trying to beat each other's system, and it is the program's beneficiaries who really suffer from it all, as more and more providers opt out of the game.

How do we find our way out of this dilemma? I certainly do not have a complete strategy, but I believe we must start by turning around the two underlying problems I have just described. First, we must realize that the "credit card" philosophy of financing health care for the poor is not a practical interpretation of the concept of mainstream medicine. We have estimated, in the California program, that if we were to remove all utilization controls from Medi-Cal, and if we paid usual and customary fees, the cost of the program would be at least 25 percent higher than it is now. For our program, that 25 percent represents one billion dollars per year, which clearly is not possible in today's era of taxpayer revolt.

We must, instead, see the mission of Medicaid as providing health care services to those who cannot afford to pay for those services, and we must understand that delivery systems and reimbursement methods are means to that end, not ends in themselves. We must measure the effectiveness of Medicaid programs in terms of their actual ability to resolve or prevent health problems among the poor, not in terms of their compliance with some philosophical principle. We would all prefer, as a social value, to permit all members of our society to have complete freedom of choice of providers of health care, but we cannot allow naive application of that principle to bankrupt our Medicaid programs.

What, then, are our reasonable alternatives in operating the Medicaid program? We suggest the following as eight alternatives which complement one another, depending on the individual State conditions:

1. Contracting with Organized Health Systems

We believe the most direct way to bring the positive elements of organized health delivery into the Medi-Cal program is to contract with those entities that meet our definition of an organized health system. This was the rationale behind our prepaid health plan program in which we have prepaid capitation contracts with HMOs and HMO-like organizations. We have already had the experience of contracting successfully with HMOs for care under the Medi-Cal program. We know for a fact that HMOs can deliver good quality care at costs ranging from 10 to 15 percent less than fee-for-service. So far, this has been our most successful cost control effort.

We also believe we are already far behind in this effort. Among the general public in California today, exclusive of Medicaid beneficiaries, more than 20 percent of the population has elected to receive care through organized health systems, such as Kaiser and Ross-Loos, which deliver good quality health care at a cost significantly less than fee-for-service. At present, we have only four percent of our Medi-Cal beneficiaries enrolled in our prepaid health plans. We need to be taking better advantage of the private sector's success in efficient health care delivery.

We are hoping to be able to contract with other organizations, similar to HMOs, which may not necessarily follow the Federal HMO model and may include payment arrangements other than full-risk capitation.

2. Contracting with County Health Systems

In California, as in the majority of States, counties have always legally been the "providers of last resort" for Medi-Cal beneficiaries who could find no other providers to treat them, and for other indigents who do not meet Medi-Cal eligibility criteria. Our larger California counties have health systems which involve both inpatient and outpatient services and a large portion of the Medi-Cal dollar goes to support care delivered through these systems. However, Medicaid reimbursement discriminates against outpatient services, even though this setting is demonstrably more effective and less costly than the inpatient setting. Therefore, a hospital will be better off financially if it provides a relatively smaller ratio of outpatient visits to inpatient admissions which are reimbursed by all third party payors at rates closer to the full cost of providing the services. Since public hospitals provide a disproportionate number of outpatient visits, they are penalized by these rules.

County systems in the past have not been treated any differently than other private providers, for the most part, with no recognition paid to the fact that the State is the county's partner in a common social mission. County operated health systems can be viewed as a mechanism through which the Medi-Cal program directly provides services to beneficiaries. We intend to contract, at minimum, with county health facilities on a prospective budget or similar all-inclusive basis, so both the State and the county can avoid the administrative costs of claims processing.

3. Contracting with Providers

In addition to contracting with organized delivery systems and with counties, we would like to develop contracts with high volume Medi-Cal providers. Currently, we have a limited number of providers in the program who have high volume Medi-Cal practices and provide the bulk of the care to our beneficiaries. We want to write contracts with these providers which will be characterized by prospective determination of payment levels, all-inclusive rates, and some degree of risk assumption by the providers. The objective is to use this contracting relationship to make such providers part of an organized health care system, with other elements of the system provided by the department, either directly or through other contracts. We could, for instance, prepay primary care providers for primary care services and offer a risk-sharing arrangement related to the costs of secondary and tertiary care which would be authorized by the primary care physician.

Such arrangements would not necessarily be restricted to high volume providers. Private industry, for example, the SAFECO Company, has developed an approach with similar elements. Primary care physicians are paid on a capitation basis for the services they render. The professional role of these contracting physicians is enhanced, not diminished, because they must authorize all services to their patients that are obtained from other sources. This arrangement appears to yield the same degree of control over unnecessary hospitalizations as has been found with the more highly structured Health Maintenance Organizations.

A key element of this alternative is the limitation of the number of hospitals participating in the program, through special time-limited provider agreements. Right now, in the Medi-Cal program, less than 30 hospitals of some 600 in the State provide nearly 50 percent of the care to Medicaid recipients. We want to be able to contract with certain hospitals that meet our criteria on a prospective or other reimbursement basis. Or, if we must reimburse hospitals on a reasonable cost basis, for example, we seek the authority to exclude from our Medicaid programs those hospitals that are inefficient or even those hospitals that represent redundant capacity, not actually needed by the Medicaid population.

We also seek to bring the high volume Medicaid providers—hospitals, clinics, physician groups,and even individual physicians—under contracts that specify their obligation to serve Medicaid beneficiaries, and that provide reimbursement incentives for efficiency. In general, State Medicaid agencies should be attempting to emulate the "independent practitioner association" model of organized systems, where the organizational structure is created through a network of contractual relationships, covering only those providers that are actually needed to serve the target population.As you are all aware, California has been solidly supporting Federal legislation that would provide States this type of authority. The Senate version of the Budget Reconciliation Bill (Section 662) gives States the option to amend their State plans, subject to approval by the Department of Health and Human Services, to permit more flexible purchasing arrangements with hospitals and other institutional providers of services. Despite our very best efforts, it may not pass, primarily because of the very sensitive Freedom of Choice issue. Indeed, as a consequence of the controversy surrounding this issue, a national dialogue has developed.

Selective contracting with providers, by definition, means that not all licensed providers will be participating in Medicaid. This has earned the total opposition of the AHA and the AHB. It is my judgment that Medicaid programs can no longer afford the philosophical luxury of unlimited freedom of choice. Unlimited freedom of choice, in fact, does not exist, by virtue of provider decision not to participate in Medicaid. We should acknowledge this reality and move toward a system where there are multiple choices with guaranteed access, instead of unlimited choices with no guarantee to access.

4. Developing Volume Purchase Arrangements

I needn't tell you that good management for any large scale business, and that includes an organized health system, dictates taking advantage of the economies of scale. Under this alternative, Medicaid would use its purchasing power to reduce the cost of "inputs"—products and services required by health care professionals. We have, thus far, conceived two elements under this initiative—volume purchases of pharmaceuticals, and contracts with laboratories, on a regional basis, for exclusive purchase of nonemergency laboratory services.

5. Improving Fee-For-Service Cost Controls

I mentioned earlier that we don't believe the fee-for-service system is the "best" for Medicaid, but that it will probably always be an important part of our program, in one way or another. We intend to make improvements in the fee-for-service system, focusing on the quality of those services and determining ways to control their costs.

We have finally been successful in limiting increases in hospital costs paid by the State to ten percent. When Governor Brown first introduced this limitation in 1975, the California Hospital Association challenged this action and was successful in the Federal District Court. However, the Court of Appeals, acting on the appeal which the governor personally argued, ruled in the State's favor.

The California Department of Health Services has since amended the California State Medi-Cal plan to reflect a hospital cost control system. The plan has been approved by the Federal government and State implementing regulations became effective July 1, 1980.

The plan limits hospital reimbursements under Medi-Cal, using factors which are developed for increases in three areas: cost of living, volume (including fixed costs), and intensity (ways in which hospitals upgrade services, i.e., tests, equipment, bed upgrades). Limits are established in each area. Allowable costs under Medi-Cal become a function of the acceptable increases in each area, in relationship to total numbers of Medi-Cal discharges. Cost savings are predicted to occur, principally in the area of intensity, and are estimated in the range of $28 million per year.

6. Improving Medi-Cal Management Methods

This alternative addresses internal improvement of program management functions that cut across the lines of the first five alternatives. For instance, we need to improve the capability of our management information system and, as we move away from our traditional fee-for-service approach, it will be even more important to define the data requirements. Measures of program need, resource expenditure measures, and program evaluation techniques should determine the impact of all the various structural changes in the program.

We also feel responsible, as managers of the program, to inform those people who use services of their options under the new program. We propose that some funds be directed to educate them as to the value of the preventive health services and the choice of organized and unorganized health care systems available. On this latter item, California is implementing a new State law which requires that Medi-Cal beneficiaries be given, at the time of eligibility determination, an informed choice of Medi-Cal fee-for-service or enrolling in whatever HMOs or PHPs are available. This is a direct result of a pilot project with almost 8,000 beneficiaries in which 16 percent chose a prepaid health plan or HMO over fee-for-service when presented with an informed choice at the time of eligibility determination.

7. Encouraging Self-Help and Preventive Medicine

Medi-Cal spends millions of dollars on care for illness which could be significantly reduced by improving the health and self-reliance of its recipients.

As it now stands, Federal statutes and regulations require that Federally mandated benefits and services provided under a State plan cannot be reduced or limited on the basis of diagnosis, condition, or disease. Provisions of the Social Security Act essentially require that medical assistance afforded to individuals shall not be less in amount, duration, or scope than that available to any other individual.

There are a number of services which would be very cost effective if provided only to individuals with certain medical conditions, but which would not be cost effective and would lead only to increased utilization if made available to the Medicaid population as a whole, regardless of condition. Examples of these include personal care services for the severely handicapped, and health education and nutritional counseling for persons with such conditions as diabetes, chronic obstructive pulmonary disease, severe hypertension, heart disease, or other chronic diseases. In these examples, it is not always possible to properly target the provision of these services through the test of "medical necessity" alone, nor is it always possible to redefine the service in such a way that it automatically includes only persons with given conditions (e.g., "diabetes counseling" as a service category rather than the individual components of dietician, NMP, physician and lab tests, etc., which might comprise the service).

Federal statutory changes are therefore required to permit States to limit specific modalities of treatment within generic categories of service based on condition, diagnosis, or disease, in accordance with the principles of efficient management of the Medicaid program and accepted standards of community practice.

8. Improving Access to Health Care Through Changing Insurance Laws

If States could change the insurance laws to require extended health coverage for laid-off workers for some reasonable period of time, it would significantly delay and even avoid reliance on the Medicaid program. Unfortunately, this is not presently a viable alternative because of ERISA, the Employee Retirement Income Security Act. This was enacted in 1974 with the aim of protecting employee interests in benefit plans. Because Section 514 of ERISA preempts State regulation of employer benefit plans, it has effectively created a moratorium of indefinite length on the passage of health insurance laws. The workers whom ERISA was intended to protect are being denied the benefits which innovative, responsible State regulation could guarantee. ERISA significantly impairs the efforts of many States to ensure that their citizens have low cost, comprehensive health insurance, that their employers offer adequate benefits plans to workers, and that their employers' self-funded health and welfare benefit plans adhere to sound organizational and fiduciary standards in the operation of such plans.

Section 514 of ERISA stifles the creative and innovative health programs which States are undertaking. Many States, notably Hawaii, Minnesota, New York, Oregon, and Wisconsin have had their days, weeks, and months in court attempting to demonstrate, without much success, that they had overriding interests and concerns in improving access to health care. It is time for Congress to examine Section 514 of ERISA against its own lack of progress toward a national health program. Perhaps, as U.S. District Court Justice Renfrew noted in the ruling against Hawaii's prepaid health care act, Congress should heed the admonition that Justice Brandeis addressed to the Federal courts:

> "To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation. It is one of the happy incidents of the Federal system that a single courageous State may, if its citizens choose, serve as a laboratory, and try novel social and economic experiments without risk to the rest of the country."

I strongly suggest to you that taxpayer alarm over our burgeoning Medicaid programs should signal the "go-ahead" for the States to develop innovative, low cost mechanisms for assuring that all citizens in the State have access to a minimum standard level of health benefits, regardless of the carrier or sponsor of their health plan.

In conclusion, these are the alternatives which we see as providing States the flexibility to operate a Medicaid program in an era of cost containment. We, in California, introduced this type of package two years ago. It was defeated because of the powerful lobbying efforts of the industry. We have supported the Federal legislation to permit States to selectively contract with hospitals and other institutional providers. By all reports, the industry has been equally successful, on the national level, as this will probably not pass, although there is still some slim hope as the conferees have yet to conclude their deliberation on this issue.

But we really cannot give up. We must use the means available to us under State and Federal laws providing for pilot project authority. We must continue to press Congress for these changes to allow us to move away from almost exclusive reliance on the fee-for-service, cost-plus system toward more extensive use of organized health systems, a system of contracting with providers that would allow State agencies to emulate the functions of organized health systems. This strategy provides advantages to both providers and beneficiaries. The major advantage, from the provider perspective, is freedom from the extensive controls applied to the fee-for-service system. From the beneficiary perspective, the major advantage is guaranteed access to necessary care. Unlike fee-for-service providers, a contractor takes on the legal obligation to serve beneficiaries. Thus, the benefits of the proposed restructuring of the Medicaid program are not purely financial, but also enable us to meet Medicaid's fundamental purposes within the growing economic crisis facing publicly funded programs.

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